83-1867

83-1867

No. ..-....

IN THE

Supreme Court of the United States

October Term, 1983

SUN TOWERS, INC., *et al.*,

Petitioners,

vs.

MARGARET M. HECKLER, Secretary, DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT.

WEISSBURG AND ARONSON, INC.,
ROBERT A. KLEIN,
PATRIC HOOPER,
By PATRIC HOOPER,
2049 Century Park East,
32nd Floor, Two Century Plaza,
Los Angeles, Calif. 90067,
Counsel for Petitioners.

170PP

Question Presented.

Whether costs necessarily incurred by corporate providers of hospital services to maintain their corporate status and to facilitate the raising of investment capital ("stock maintenance costs") constitute indirect costs of providing services to Medicare patients which are required to be reimbursed under the Medicare statute and implementing regulations.*

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*The parties to this proceeding are Petitioners, Sun Towers, Inc.; Chippenham Hospital, Inc.; Johnston Willis Hospital, Inc.; Lewis Gale Hospital, Inc.; Montgomery County Hospital, Inc.; Pulaski Community Hospital, Inc.; Raleigh General Hospital; McMinnville Hospital, Inc.; Athens Community Hospital, Inc.; Parkridge Hospital, Inc.; Redmond Park Hospital, Inc.; River Park Hospital, Inc.; Humboldt Cedar Crest Hospital, Inc.; Hospital Corporation of America; Hospital Corporation of Smith and Overton Counties; De Kalb General Hospital, Inc.; Broadway Hospital, Inc.; Ross General Hospital; Sebastopol Hospital Corp.; Ukiah Hospital Corporation; Trinity Hospital, Inc.; Donelson Hospital, Inc.; West Paces Ferry Hospital, Inc.; Doctors Hospital of Mobile, Inc.; Selma Medical Center Hospital, Inc.; University Hospital, Inc.; HCA-Arlington, Inc.; Greenview Hospital, Inc.; Community Hospital, Inc.; Malone Hogan Hospital, Inc.; Circle Terrace Hospital; Diagnostic Center Hospital Corporation of Texas; Pasadena Bayshore Hospital, Inc.; Rio Hondo Memorial Hospital; Los Robles Regional Medical Center; De Tar Hospital, Inc.; Fort Worth Medical Plaza, Inc.; North Florida Regional Hospital, Inc.; Marion Community Hospital, Inc.; Lakeland Manor, Inc.; Hartselle Medical Center, Inc.; Crestwood Hospital and Nursing Home; Hospital Development Service Corporation; and Respondent Margaret M. Heckler, Secretary of the Department of Health and Human Services.

TABLE OF CONTENTS

INDEX TO APPENDIX

TABLE OF AUTHORITIES

Federal Register

Federal Regulations

Statutes

Textbooks

No. ..-....

IN THE

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SUN TOWERS, INC., *et al.*,

Petitioners,

vs.

MARGARET M. HECKLER, Secretary, DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT.

Petitioners respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Fifth Circuit entered in this proceeding on February 21, 1984, upholding the decision of the Secretary of Health and Human Services ("Secretary").

Opinion Below.

The opinion of the Court of Appeals is reported at 725 F.2d 315 (5th Cir. 1984) and is appended as Exhibit A. The unreported opinion of the District Court is appended as Exhibit B. The decisions of the Secretary and the Provider Reimbursement Review Board are appended as Exhibits C and D, respectively. The judgments of the Court of Appeals and the District Court after remand are appended as Exhibits E and F, respectively.

Jurisdiction.

The opinion of the Court of Appeals was issued on February 21, 1984. A timely petition for rehearing was denied on April 2, 1984, and this petition for certiorari was filed within the time permitted by law. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

Statutory and Regulatory Provisions Involved.

The following statutes, regulations and agency guidelines are relevant to this matter and appear in pertinent part in the Appendix at Exhibit G:

42 U.S.C. § 1395f(b)
42 U.S.C. § 1395x(v)(1)(A)
42 U.S.C. § 1395oo
42 C.F.R. § 405.402
42 C.F.R. § 405.406
42 C.F.R. § 405.419
42 C.F.R. § 405.429
42 C.F.R. § 405.451
Provider Reimbursement Manual § 2134.1
Provider Reimbursement Manual § 2134.9
Provider Reimbursement Manual § 2150
Provider Reimbursement Manual § 2150.2B

Statement of the Case.

This case involves the interpretation of the Medicare Statute and regulations regarding reimbursement for hospital inpatient services rendered to Medicare beneficiaries. Reimbursement is governed by 42 U.S.C. §§ 1395f(b) and 1395x(v)(1)(A) and 42 C.F.R. § 405.401 *et seq.*, which require the Secretary to reimburse "providers" of hospital inpatient services on the basis of their actual, direct *and indirect* costs of rendering care so long as such costs are (1) reasonable in amount and (2) related to patient care. *See*

42 C.F.R. § 405.451; Appendix at 112-14. The latter requirement is involved in this controversy.

Petitioners are corporations certified by the Secretary to provide hospital services to Medicare beneficiaries. Hospital Corporation of America ("HCA"), petitioners' parent company and their "home office" under Medicare, began operations as a single hospital in 1968. Thereafter, HCA rapidly began to acquire and construct other hospitals, principally in the South and Southwest. By 1973, the cost year in dispute, HCA owned and operated the numerous Medicare hospital providers who are the petitioners in this proceeding. 725 F.2d 318-19; Appendix at 5.

The Secretary recognizes that home offices, such as HCA, provide central management and administrative services to their member hospitals. Thus, Medicare reimburses the member hospitals for the allocable portion of the costs of home office services as part of the hospitals' allowable, indirect costs of providing patient care. *See* Provider Reimbursement Manual ("HIM-15") § 2150, Appendix at 115-17. (HIM-15 contains the Secretary's informal interpretations of the Medicare regulations. *See* 725 F.2d at 325, note 16; Appendix at 19.)

During 1973, HCA incurred over $180,000 in expenses, referred to by the Secretary as "stock maintenance costs," consisting primarily of (1) stock transfer and registration fees; (2) the costs of reports to stockholders; (3) the costs of stockholders' meetings; and (4) legal and accounting fees incurred through SEC filings and stockholders' meetings. 725 F.2d at 326; Appendix at 20-21.

Petitioners claimed these costs as part of their indirect costs of operating and maintaining patient care facilities on their individual Medicare cost reports for the 1973 fiscal

period.[1] The fiscal intermediary disallowed the claimed stock maintenance costs. 725 F.2d at 319; Appendix at 5.

Petitioners appealed the intermediary's disallowance to the Provider Reimbursement Review Board ("Board"), a five-member panel of Medicare reimbursement experts authorized by Congress pursuant to 42 U.S.C. § 1395oo(h) to resolve Medicare reimbursement disputes. 725 F.2d at 326; Appendix at 20. The Board concluded that stock maintenance costs are allowable, indirect costs of providing services and must be reimbursed under the Medicare statute and regulations. Appendix at 80-96.

The Secretary subsequently reversed the Board concluding that the costs in question were incurred *primarily* for the benefit of HCA's stockholders and thus were not *primarily* related to actual patient care or necessary to the rendition of patient care services. 725 F.2d at 326; Appendix at 21.

Petitioners sought judicial review of the Secretary's decision in the United States District Court for the Western District of Texas, at El Paso. Relying heavily on the Court of Claims decision in *AMI-Chanco, Inc. v. United States*, 576 F.2d 320 (Ct.Cl. 1978), the District Court, exercising jurisdiction under 42 U.S.C. § 1395oo, reversed the Secretary.[2] The District Court held, *inter alia*, that the disallowance of stock maintenance costs conflicts with the Med-

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[1]Providers are required annually to file cost reports (a document similar to a tax return) setting forth their direct and indirect costs of providing services to hospital patients during a particular fiscal period. The Secretary's designated Medicare fiscal intermediary audits the reports and makes the initial determination of "allowable costs." *See Pacific Coast Medicare Enterprises v. Harris*, 633 F.2d 123, 126 (9th Cir. 1980).

[2]Because of its importance to this proceeding, the *AMI-Chanco* decision is appended as Exhibit H.

icare statute and regulations. 725 F.2d at 327-28; Appendix at 24.

The Court of Appeals chose to "differ with" the Court of Claims' decision in *AMI-Chanco* (and with the District Court) and decided, instead, to rely on the decision in *American Medical International, Inc. v. Secretary of Health, Education and Welfare*, 466 F.Supp. 605, 612-13 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981). Thus, the Court of Appeals reversed the District Court and affirmed the Secretary's decision disallowing reimbursement of stock maintenance costs.

REASONS FOR GRANTING THE WRIT.

1. The Decision Below Directly Conflicts With the Decision of Another Court of Appeals as to the Proper Interpretation of the Medicare Statute and Regulations.

The Court of Appeals' decision in this case is in direct and complete conflict with the decision of the Court of Claims (now the Court of Appeals for the Federal Circuit, 28 U.S.C. § 1295) in *AMI-Chanco*. The Fifth Circuit concluded it did "not find that the Secretary's decision is irrational or inconsistent with the purpose of the enabling legislation," despite recognizing that petitioners "have advanced strong arguments favoring the reimbursement of stock maintenance costs." 725 F.2d at 330; Appendix at 28.

On the other hand, the Court of Claims in *AMI-Chanco*, interpreting the very same statute and regulations and acknowledging the very same limits on its authority to review the Secretary's Medicare decisions, concluded that:

> It is not often that we face circumstances so compelling that the ends of justice pursuade us to characterize an administrative decision as arbitrary or capricious. However, we find that the decision in this case is so inconsistent with the statutory purpose and other regulations of the same agency that we cannot uphold that decision. Although "stock maintenance expenses" are a special classification coined by H.E.W., we find that they are actually general and administrative expenses, which are indirectly related to and necessarily incurred in providing the Medicare services involved in this case.

576 F.2d at 326; Appendix at 130.

Not surprisingly, the Fifth Circuit and the Court of Claims reached totally different conclusions regarding each of the arguments advanced by the parties before them in support

of their respective positions. Although both Courts agreed (1) that the Medicare statute requires reimbursement of the *indirect costs* of patient care, (2) that corporate providers are expressly recognized as "acceptable providers" under Medicare, and (3) that so-called stock maintenance costs are necessary for the maintenance of corporate providers, (576 F.2d at 323; Appendix at 123, and 725 F.2d at 327-29; Appendix at 22-27), the Court of Claims concluded that stock maintenance costs were allowable indirect costs of patient care while the Fifth Circuit concluded they were not.

In so concluding, the Fifth Circuit (1) accepted the Secretary's unwritten, *ad hoc* imposition of a subjective standard, *i.e.*, that the "primary purpose" underlying a claimed cost, even an indirect cost such as depreciation or interest (*see*, 42 C.F.R. §§ 405.415 and 405.419), must be the rendering of patient care, and (2) expressly chose "to differ" with the Court of Claims' conclusion that the interpretation is not consistent with the Medicare statute and is unreasonable and irrational. 725 F.2d at 328; Appendix at 24.

The difference of opinion may well be explained by the fact that the Court of Claims expressly relied on, while the Fifth Circuit ignored, 42 C.F.R. § 405.451, the *only* Medicare regulation which specifically discusses the concept of "costs related to patient care" ("costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities").[3]

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[3]Other courts have also relied on Section 405.451 in interpreting the Medicare statute regarding the allowability of indirect costs. *See, e.g., Annie M. Warner Hospital v. Harris*, 639 F.2d 961, 966 (3rd Cir. 1981) [special dues and assessments paid by hospitals to an association to obtain funds for the capitalization of a malpractice insurance company were sufficiently related to patient care under Section 405.451(b)(2) to be allowable since they were "appropriate and helpful in developing and maintaining the operation of patient care facilities."]

The Court of Claims reasoned that because corporate providers could not permissibly operate without incurring legally mandated stock maintenance costs, such costs were essential to the maintenance and development of patient care facilities and activities, and thus allowable under Section 405.451. The Court of Claims added "[i]t may be that these [state and federal securities] laws were enacted for the benefit of investors, but the fact remains that Chanco must legally incur these costs in order that it may attract the equity capital which is necessary for its operation of facilities to provide patient care services." 576 F.2d at 323; Appendix at 123.

The Fifth Circuit also summarily rejected the conclusion reached by the Court of Claims (576 F.2d at 323; Appendix at 123-24) as well as by the District Court (Appendix at 55) that disallowing stock maintenance costs will cause non-Medicare beneficiaries to subsidize the costs of services rendered to Medicare beneficiaries in violation of the Medicare statute, 42 U.S.C. § 1395x(v)(1)(A), 725 F.2d at 328; Appendix at 25.[4]

Additionally, while recognizing that non-profit corporate providers are reimbursed for many of the same costs as the costs incurred here by proprietary corporate providers (*e.g.*, the costs of annual corporate meetings and reports), the Fifth Circuit rejected the holding of the Court of Claims (576 F.2d at 324; appendix at 125) and the District Court (Appendix at 55) that the Secretary's refusal to pay for stock

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[4]The District Court's and the Court of Claims' conclusions regarding "cross-subsidization" are consistent with the recent decisions of the Court of Appeals in *St. Mary of Nazareth Hosp. Center v. Schweiker*, 718 F.2d 459 (D.C. Cir. 1983), and *Intern. Philanthropic Hosp. Foundation v. Heckler*, 724 F.2d 1368 (9th Cir. 1984), holding that Medicare's failure to pay its share of the costs of a hospital causes non-Medicare patients to bear a disproportionate share of the hospital's costs in violation of the Medicare statute.

maintenance costs was inconsistent with the Medicare regulation, 42 C.F.R. § 405.402(b)(5), which requires equitable treatment of non-profit and proprietary providers. 725 F.2d at 328; Appendix at 24-25.

Moreover, although the Fifth Circuit recognized that stock maintenance costs are considered part of a hospital's general and administrative costs under generally accepted accounting principles, which would support their reimbursement under 42 C.F.R. § 405.406, the Court held that Section 405.406 "is not a regulation affecting the substantive provisions of the program as to what constitutes reimbursable costs." 725 F.2d at 329; Appendix at 26. The Court of Claims, on the other hand, stressed the importance of Section 405.406, and its incorporation of standardized accounting practices, in determining whether the Medicare statute requires indirect costs, such as stock maintenance costs, to be allowed under the Medicare statute. 576 F.2d at 323-24; Appendix at 124-25.[5]

The Fifth Circuit and the Court of Claims also disagreed over whether the Secretary's refusal to pay for stock maintenance costs is consistent with the Secretary's policy of reimbursing the costs of raising and retaining investment capital in the hospital industry. The Court of Claims held that reimbursement of stock maintenance costs is consistent with 42 C.F.R. §§ 405.429 and 405.419, which are intended to create incentives to retain private capital in the hospital industry and to enable providers to raise additional capital when necessary and appropriate for the maintenance and development of patient care facilities. 576 F.2d at 324-

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[5]The Court of Claims' reliance on generally accepted accounting principles is consistent with the decisions in *Villa View Community Hosp. Inc. v. Heckler*, 720 F.2d 1086, 1093 (9th Cir. 1983) and *Pacific Coast Medical Enterprises v. Harris*, *supra*, 633 F.2d at 132.

25; Appendix at 126-27. The Fifth Circuit, however, relying once again on the "primary purpose" reasoning, concluded that stock maintenance costs are somehow different from all other costs of raising capital, such as raising grant capital or debt capital, because they are allegedly not incurred "primarily" for providing medical care. 725 F.2d at 329; Appendix at 27-28.

Finally, the Court of Claims asserted two other reasons for concluding that stock maintenance costs must be allowed by Medicare, which the Fifth Circuit did not even discuss. First, the Court of Claims held that it failed to perceive "any rational basis for treating the costs of *creating* a corporate entity [costs similar to those here] as allowable, indirect expenses of patient care, while disallowing stock maintenance costs that are essential to the *maintenance* of the corporate organization." (Emphasis added.) 576 F.2d at 324; Appendix at 125. Second, the Court of Claims noted that the Secretary's treatment of stock maintenance costs is inconsistent with the treatment afforded the very same costs by other federal agencies in related fields. 576 F.2d at 320-21; Appendix at 128-29.[6]

One cannot imagine a clearer conflict between the Courts than that existing between the Fifth Circuit and the Court of Appeals for the Federal Circuit. This Court has not hesitated to grant certiorari to resolve conflicts between a Court of Appeals and the Court of Claims, especially where, as discussed below, important questions of statutory interpre-

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[6]Although the Fifth Circuit ignored the practices of other federal agencies in related fields in this case, it noted the importance of these practices in another of its decisions involving Medicare reimbursement. *See Homan & Crimen, Inc. v. Harris*, 626 F.2d 1201, 1208 (5th Cir. 1980). *See also Pacific Coast Medical Enterprises v. Harris, supra*, 633 F.2d at 132, in which the Court relied on the practices of other agencies.

tation impacting on the administration of a critical federal program are raised. *See United States v. Hopkins*, 427 U.S. 123 (1976); *C.I.R. v. Idaho Power Co.*, 418 U.S. 1 (1974); *C.I.R. v. National Alfalfa Dehydrating & Milling Co.*, 417 U.S. 134 (1974).

2. The Decision Below Involves Important Questions Concerning the Interpretation of the Medicare Statute and the Administration of the Medicare Program.

The affirmance of the Secretary's decision disallowing reimbursement of stock maintenance costs will clearly diminish the availability of capital necessary for developing and maintaining patient care facilities and providing quality patient care services.

Significantly, petitioners are not alone in their belief that the stock maintenance costs issue is of great import. In refusing to abide by the Court of Claims decision in *AMI-Chanco*, the Court of Appeals for the District of Columbia Circuit in *American Med. Intern. v. Sec. of Health, etc.*, 677 F.2d 118 (D.C. Cir. 1981), characterized the stock maintenance costs issue as "one of national import" (677 F.2d at 121, note 24) and as a legal issue "with substantial public policy implications" (677 F.2d at 122). The Court apparently even contemplated Supreme Court review since it held that independent reconsideration by different circuits of certain important legal issues, such as the stock maintenance costs issue, "can facilitate Supreme Court review by highlighting their complications and controversial aspects." (677 F.2d at 122.)

The Fifth Circuit's decision and the Court of Claims' decision are so inconsistent as to leave the intent and meaning of the Medicare statute and regulations in a state of confusion. Because the issue is of continuing importance and is involved in numerous cases presently pending in the

lower courts and before the Secretary and the Provider Reimbursement Review Board, a timely and definitive ruling on the issue by this Court is critical.

The stock maintenance costs issue is currently pending before the United States Court of Appeals for the District of Columbia Circuit in *Humana, Inc. v. Schweiker, Secretary of HEW*, Case No. 82-1986.[7] The issue also continues to be an important one in the Court of Appeals for the Federal Circuit. For example, the United States Claims Court, in *Alexander Hospital, Inc. et al. v. The United States*, No. 345-81C, filed March 30, 1984 (Appended as Exhibit I), after emphasizing the substantial and ongoing conflict between the courts and between the Secretary and the Board on the issue, followed the holding in *AMI-Chanco*.

Additionally, even though the Court of Claims (now the Court of Appeals for the Federal Circuit) jurisdiction extends only to pre-1973 Medicare reimbursement disputes (*see, e.g., Spokane Valley General Hosp., Inc. v. United States*, 688 F.2d 771, 775-76 (Ct.Cl. 1982)), there are several Medicare reimbursement disputes now pending at the administrative agency level relating to pre-1973 fiscal periods which will ultimately be presented to the Claims Court for resolution.[8]

Moreover, the stock maintenance costs issue continues to be a very important one before the Provider Reimburse-

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[7]Although the *Humana* case was argued and submitted on April 22, 1983, more than a year ago, a decision has yet to be issued by the Court despite the previous holding of the same Court in *American Med. Intern. v. Sec. of Health, etc., supra*. Given this delay, one cannot help but speculate that the Court is troubled by the various conflicting court and agency opinions.

[8]Present counsel represent numerous Medicare providers challenging the Secretary's stock maintenance costs policy for pre-1973 fiscal periods, which cases will ultimately be presented to the United States Claims Court, and if necessary, to the United States Court of Appeals for the Federal Circuit for resolution.

ment Review Board regarding disputes for 1973 and subsequent fiscal years. Fifty of the cases decided by the Board during the first calendar quarter of 1984 involved the stock maintenance cost issue. Presumably, these cases will result in court review unless the controversy is finally and definitively resolved by this Court.

Not only is the stock maintenance costs issue a significant one in the federal courts and the federal Medicare agencies, it is also an important issue in the state courts and state agencies of those many states using Medicare reimbursement principles to determine Medicaid reimbursement. For example, the issue is presently pending regarding various hospitals participating in California's Medi-Cal program. At least one such case has been decided by a California trial court (Appended as Exhibit J) and has been appealed to the California appellate courts.

Significantly, the conflicting reasoning of the Fifth Circuit and the Court of Claims has impact beyond the stock maintenance cost issue. Courts resolving *other* Medicare reimbursement disputes have relied on the reasoning of the Court of Claims in *AMI-Chanco*. (*See, e.g., Pacific Coast Medical Enterprises v. Harris, supra*, 633 F.2d at 131, note 30.) The Fifth Circuit's contrary reasoning creates confusion concerning the precedential value of *AMI-Chanco* and the cases relying on its analysis.

Finally, it must be emphasized that even though Medicare reimbursement has recently changed from a retrospective, cost-based reimbursement system to a prospective payment system, the stock maintenance costs issue continues to be of great significance. As indicated above, there are many pending disputes governed by the reasonable cost system (pre-1983 fiscal years). Moreover, the issue is involved in the determination of a portion of individual hospitals' prospective payment rates under the new prospective payment

system. (*See* 49 Fed. Reg. 235-340, January 3, 1984, for the details and background of the Medicare prospective payment system.)

Where, as here, conflicting lower court decisions create confusion regarding the meaning of a statute necessary to the administration of an important federal program, and the issue is pending in the lower courts and in agency proceedings, this Court has granted certiorari to reconcile the conflict. *See Laing v. United States*, 423 U.S. 161, 167 (1976) and *F.T.C. v. Jantzen, Inc.*, 386 U.S. 228, 229 (1967).

Conclusion.

For the reasons set forth above, it is respectfully submitted that a writ of certiorari should issue to review the judgment and opinion of the Fifth Circuit.

Respectfully submitted.

WEISSBURG AND ARONSON, INC.,
ROBERT A. KLEIN,
PATRIC HOOPER,
By PATRIC HOOPER,
Counsel for Petitioners.

APPENDIX A.

Opinion.

Sun Towers, Inc., et al., Plaintiffs-Appellants Cross-Appellees, v. Margaret M. Heckler,* Secretary, Department of Health and Human Services, Defendant-Appellee Cross-Appellant.

No. 82-1481.

United States Court of Appeals, Fifth Circuit.

Feb. 21, 1984.

Weissburg & Aronson, Inc., Ronald N. Sutter, Washington, D.C., Robert A. Klein, Patric Hooper, Los Angeles, Cal., for Sun Towers, Inc.

Thomas W. Coons, Health Care Financing Div., Dept. of HHS, Baltimore, Md., Anthony J. Steinmeyer, Atty., Civ. Div., Wendy M. Keats, Washington, D.C., for Margaret M. Heckler.

Appeals from the United States District Court for the Western District of Texas.

Before BROWN and RANDALL, Circuit Judges, and HUNTER**, District Judge.

RANDALL, Circuit Judge:

Plaintiffs in this suit are forty-seven hospitals that are owned and operated by Hospital Corporation of America ("HCA"). The defendant is the Secretary of Health and Human Services, who is responsible for the administration of Title XVIII of the Medicare Act, 42 U.S.C. §§ 1395 *et seq.* (1976 & Supp. V 1981). The Medicare Act requires

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*The name of the present Secretary is ordered substituted for the name of her predecessor, Richard S. Schweiker, pursuant to Fed.R.App. 43(c).

**District Judge of the Western District of Louisiana, sitting by designation.

the Secretary tc reimburse provider hospitals for the reasonable costs of treating Medicare patients. The Act also requires the Secretary to pay corporate providers of such services a return on equity invested in hospital facilities. The plaintiffs petitioned the district court to review a final decision of the Secretary denying payment of the following costs and returns on equity capital claimed by the plaintiffs to be due to them under Medicare:

> (1) Stock maintenance costs—costs attributable to stock transfer and registration fees, mandatory filings with the Securities and Exchange Commission ("SEC"), stockholders' meetings, and public relations directed at institutional investors;
>
> (2) A return on equity capital invested in goodwill that was purchased through 100% stock acquisitions of hospitals;
>
> (3) Costs of unconsummated acquisitions; and
>
> (4) A return on equity capital invested in aircraft used in the construction of HCA hospitals.

Both the plaintiffs and the Secretary moved for summary judgment. The district court granted the plaintiffs' motion for summary judgment on the stock maintenance costs issue, but granted the Secretary summary judgment with respect to the other issues.

On appeal, the plaintiffs argue that the Secretary's disallowance of unsuccessful acquisition costs and returns on net equity in goodwill and in aircraft used in hospital construction is arbitrary and capricious. Moreover, the plaintiffs also contend that the Secretary's disallowance of these costs was untimely, and hence invalid. The Secretary argues that the stock maintenance costs were properly disallowed and that the district court erred in finding to the contrary.

For the reasons set forth below, we hold that the district court erred in reversing the Secretary's disallowance of the

stock maintenance costs and thus reverse on this issue. We affirm, however, the district court's summary judgment against the plaintiffs with regard to the other three claims, and find that the Secretary's disallowance of these claims was timely.

I. BACKGROUND.

A. Medicare.

This case arises under Title XVIII of the Social Security Act, known as the Medicare program. 42 U.S.C. §§ 1395a-1395xx. This legislation provides for federal reimbursement of medical care for the aged and certain disabled persons. 42 U.S.C. § 1395c. It accomplishes this, in part, through contractual arrangements with medical facilities to be "providers" of such medical care.[1] These providers afford certain covered medical services to the program's beneficiaries, for which they receive reimbursement from the government. 42 U.S.C. § 1395f. A provider is reimbursed for the "reasonable cost" of the services provided or, if lower, the customary charges for such services. 42 U.S.C. § 1395f(b)(1) (1976). In addition to "reasonable costs," Medicare also pays, in certain instances, a "reasonable return on equity capital, including necessary working capital, invested in a facility and used in the furnishing of services. . . ." 42 U.S.C. § 1395x(v)(1)(B). Under this return on equity capital principle, proprietary providers, such as the plaintiffs, receive a specific return on their "investment

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[1] 42 U.S.C. § 1395x(u):

> The term "provider of services" means a hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, or home health agency, hospice program, or, for purposes of section 1395f(g) and section 1395n(e) of this title, a fund.

An entity is an authorized Medicare provider by virtue of a contract, called an 1866 agreement, between it and the Secretary. Such contracts arise under § 1866 of the Social Security Act, 42 U.S.C. § 1395cc.

in plant, property, and equipment related to patient care," and on their "net working capital maintained for . . . patient care activities." 42 C.F.R. § 405.,429(b) (1982).

A provider may be reimbursed for services rendered to Medicare beneficiaries directly by the Secretary, or it may appoint as a "fiscal intermediary" any qualified public or private agency to act as the Secretary's agent for the purpose of reviewing its claims and administering payments due it from the government. These private entities are frequently health and accident insurance companies such as Blue Cross and Aetna. Each provider files an annual cost report with its fiscal intermediary, which audits the report and then issues a notice of program reimbursement informing the provider of the amount of reimbursement to which it is entitled. 42 C.F.R. § 405.1803 (1982). If a provider is dissatisfied with the fiscal intermediary's determination, it may request a hearing on this matter before the Provider Reimbursement Review Board (the "Board")[2] 42 U.S.C. § 1395*oo*(a). The Board's determination is the final agency action unless the Secretary, "on his own motion," reverses or modifies the Board's decision. 42 U.S.C. § 1395*oo*(f)(1). The Secretary has delegated her authority to review the Board's decision to the Administrator of the Health Care Financing Administration ("HCFA").[3] The Administrator has, in turn, re-delegated this authority to the Deputy Administrator. The provider has a right to judicial review from the Board's decision or from the Secretary's subsequent action.

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[2]The Board consists of five members appointed by the Secretary. All five must be expert in the area of cost reimbursement; at least one must be a certified public accountant. 42 U.S.C. § 1395*oo*(h).

[3]42 Fed.Reg. 13,262 (1977) and 42 Fed.Reg. 57,351 (1977).

B. Facts.

HCA began operations in 1968 as a single hospital. It rapidly began to acquire and construct other hospitals, principally in the South and Southwest. By 1973, the cost year in dispute, HCA owned and operated forty-seven hospitals.

Plaintiffs are the forty-seven Medicare providers in the chain owned and operated by HCA, which serves as the home office. Medicare recognizes that home offices provide central management and administrative services, and reimburses home office costs to the extent these services relate to patient care. In 1973, certain "home office" expenses were claimed on HCA's home office cost report to be allocated to the members in the chain. HCA's fiscal intermediaries, however, disallowed these costs and the plaintiffs took a group appeal to the Board. The Board found in favor of the plaintiffs on four of six issues. Thereafter, the Secretary reversed the Board's decision on the four issues decided in favor of the plaintiffs. The plaintiffs then sought judicial review before the district court, challenging the Secretary's reversal of the Board's decision, and contending that the Secretary's decision was untimely.[4] The four disputed issues are (1) stock maintenance costs, (2) return on goodwill, (3) unsuccessful acquisition costs, and (4) return on aircraft equity. Subsequently, the district court upheld the Secretary's decision on all but the stock maintenance costs issue.

II. TIMELINESS OF THE SECRETARY'S DECISION.

Because the timeliness of the Secretary's decision necessarily determines whether we must consider the merits, we address this issue first.

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[4]The plaintiffs did not seek judicial review of the Board's decision with regard to the two issues decided in favor of the intermediaries.

Both the Secretary's review process and judicial review of her decisions are governed by 42 U.S.C. § 1395*oo*(f)(1). This section provides in pertinent part:

> (1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received.

Thus, under the plain wording of the statute, the Secretary's decision is without legal effect if it was rendered more than "60 days after the provider of services [was] notified of the Board's decision . . . ."

The Board's decision is dated January 2, 1980. On the same day it was mailed to the plaintiffs and hand-delivered to the Office of the Attorney-Advisor, which is responsible for preparing the Deputy Administrator's decisions. The plaintiffs received the Board's decision on January 7, 1980.

The Deputy Administrator's decision reversing the Board on all four issues presently upon appeal is dated March 6, 1980, 64 days after the Board's decision was rendered but 59 days after it was received by the plaintiffs. The letters transmitting copies of the Deputy Administrator's decision are dated March 11, 1980, 69 days after the Board's decision and 64 days after the plaintiffs received the Board's decision.

The plaintiffs contend that the Secretary's decision is untimely for three reasons. First, they argue that the 60-day statutory period allowed for secretarial reversals of the Board begins to run from the date the Board's decision is rendered

and mailed to the parties. Thus, the Secretary's decision is invalid because it is dated more than 60 days after the Board's decision was mailed to the parties. Second, the plaintiffs maintain that the Secretary is collaterally estopped from contesting that the 60-day period runs from the date of the Board's decision as a result of an earlier court decision adverse to the Secretary on this issue. Third, the plaintiffs argue that the date the Secretary's reversal became effective is the date on which the decision became a matter of public record, rather than the date affixed to the decision. Therefore, the Secretary's decision became "public" when mailed to the plaintiffs on March 11, 1980, more than 60 days after the Board's decision was rendered and received by the plaintiffs.

A. Meaning of "is notified."

The plaintiffs contend that the term "is notified," as used in the first sentence of section 1395*oo*(f)(1), should be interpreted as occurring on the date the Board's decision is *mailed* to the provider, rather than the date on which the provider *receives* this decision. Thus, they argue that the Secretary's decision was untimely because it is dated March 6, 1980, 64 days after the Board's decision was mailed to the plaintiffs. In support of this contention, they note the term "is notified," used in the first sentence of the section 1395*oo*(f)(1), is in marked contrast to the second sentence establishing a 60-day period for obtaining judicial review. The second sentence expressly states that a civil action seeking review of the agency's decision must be "commenced with 60 days of the date on which notice *is received*." (Emphasis added.) The plaintiffs note also that we have held that it is an "established rule of construction that a term carefully employed in one place and excluded in another should not be implied where excluded." *KCMC, Inc. v.*

F.C.C., 600 F.2d 546, 550 (5th Cir.1979). *See also Diamond Roofing Co. v. Occupational Safety and Health Review Commission*, 528 F.2d 645, 648 (5th Cir.1976). Thus, they contend that the fact that the second sentence of section 1395*oo*(f)(1) expressly refers to the receipt of notice but the first sentence does not clearly indicates that receipt is not a requirement of the notice referred to in the first sentence of the section.

We do not find that the use of the term "is received" in the second sentence of section 1395*oo*(f)(1) precludes us from interpreting "is notified" to mean when notice of the Board's decision is received. Arguably, the common understanding of "is notified' is that of actual notice, and the term is synonymous with "is received." Simply because Congress used "is notified" with regard to the secretarial review provision, rather than "is received," as was used in connection with judicial review, is not reason enough for us to find that the terms were intended to have different meanings.

Our review of the statute's legislative history, which the plaintiffs ignore, lends considerable weight to this view. In its original form section 1395*oo*(f) read, in pertinent part, as follows:

> (f) A decision of the Board shall be final unless the Secretary, on his own motion, and within *60 days after the provider of services is notified of the Board's decision*, reverses or modifies (adversely to such provider) the Board's decision. In any case where such a reversal or modification occurs the provider of services may obtain a review of such decision by a civil action commenced within *60 days of the date he is notified of the Secretary's reversal or modification*.

86 Stat. 1420, 1422 (1972) (emphasis added).

Thus, section 1395*oo*(f), when enacted in 1972, employed the term "is notified" with respect to both the secretarial and judicial review portions of the statute. The House Committee on Ways and Means report accompanying this legislation interpreted the "is notified" language of the secretarial review provision to mean that "the Board's decision shall be final unless reversed or modified . . . within 60 days after the provider *receives* notification of the Board's decision." H.R.Rep. No. 92-231, 92d Cong., 1st Sess., *reprinted in* 1972 U.S.Code & Ad.News 4989, 5309 (emphasis added). Similarly, with regard to the judicial review portion of the statute, the Committee interpreted the "is notified" language to mean that a provider could obtain judicial review of the Secretary's decision "if such action is filed within 60 days of *receipt of notice* of the Secretary's determination." *Id.* (emphasis added). Thus, the legislative history of section 1395*oo*(f)(1) demonstrates that Congress interpreted the term "is notified" to mean the date upon which notice is received. The terms "is notified," "receives notification," and "receipt of notice" were used interchangeably and treated as being synonymous.

In 1974, Congress amended section 1395*oo*(f) to expand the availability of judicial review of cases where the Secretary chooses not to modify or reverse a Board decision. The second sentence of section 1395*oo*(f)(1) was modified to read that an action for judicial review would have to be commenced within "60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received." In enacting this amendment, Congress left untouched the "is notified" language of the secretarial review portion of section 1395*oo*(f)(1).

The plaintiffs would have us believe that Congress' failure to change the "is notified" language of the secretarial re-

view provision so as to parallel the "is received" modification in the judicial review provision demonstrates that Congress intended "is notified" to mean something other than receipt of notice. We note that the Congressional reports accompanying the 1974 amendment fail to suggest that Congress, in enacting the amendment, intended to alter its understanding of "is notified" to mean something different than "is received." Furthermore, when the amendment was first introduced to the Senate, Senator Walter F. Mondale explained that the amendment was for the sole purpose of offering providers the right of judicial review of any Board decision or subsequent modification or reversal by the Secretary. Senator Mondale noted that "[t]his amendment would not alter in any way the administrative appeals procedures currently provided for in [section 1395*oo*(f)(1)]." 119 Cong.Rec. 38,631 (1974). In light of this legislative history, we are reluctant to interpret "is notified" and "is received" as having different meanings.

The plaintiffs argue next that the term "is notified" contained in the secretarial review provision of section 1395*oo*(f)(1) must be interpreted to occur on the date of mailing in order to be consistent with the Secretary's interpretation of the word "notice" in 42 U.S.C. § 1395*oo*(a)(3). That section allows a provider to appeal to the Board "within 180 days after notice of the intermediary's final determination . . . ." *Id.* The Secretary's regulation provides that this appeal must be filed "within 180 days of the date the *notice* of the intermediary's determination . . . was *mailed* to the provider . . . ." 42 C.F.R. § 405.1841(a) (emphasis added). This regulation interprets the statutory term "notice" as occurring on the date of mailing. Thus, the plaintiffs argue, if the intermediary's notice to the provider occurs on the date of mailing, consistency requires the Board's notice to the provider referred to in the first sentence of section

1395*oo*(f)(1) also to occur on the date of mailing.

The House Committee report accompanying section 1395*oo*(a)(3) states that, in order to obtain Board review, the provider must file a request for a hearing "within 180 days *after notice* of the intermediary's final determination." H.R.Rep. No. 92-231, 92d Cong., 1st Sess., *reprinted in* 1972 U.S.Code Cong. & Ad.News 4989, 5309 (emphasis added). Thus, the Secretary's interpretation of "notice" to mean the date of mailing, rather than the date of receipt, is neither supported nor contradicted by the legislative history. But the issue of whether the Secretary's interpretation of "notice" in section 1395*oo*(a)(3) is reasonable is not before us and, in any case, we cannot allow the Secretary's interpretation of another subsection of the statute to override Congress' clear understanding of "is notified" as employed in section 1395*oo*(f)(1). While the Secretary's regulations accompanying section 1395*oo*(f)(1) could have been more explicit as to the meaning of "is notified,"[5] we interpret the term to mean receipt of notice.[6]

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[5]At the time the Deputy Administrator's decision was rendered, 42 C.F.R. § 405.1875 provided in pertinent patt:

> (b) The Secretary will promptly notify all parties to the Board's hearing of his election to review the Board's decision and of the result of such review.
>
> (c) If the Secretary reverses, affirms, or modifies a decision of the Board, he must do so within 60 days after notification to the provider of the Board's decision.

Subsequent to oral argument in this case, § 405.1875 was amended to provide that if the Administrator decides to review a Board's decision, "the Administrator will make this decision within 60 days after the provider received notification of the Board decision and will promptly mail a copy of the decision to each party and to HCFA." 48 Fed.Reg. 45,774 (1983) (to be codified at 42 C.F.R. § 405.1875(g)(2)). This change arose from the need "to clarify procedures and policies that have been identified through experience as subject to differing interpretations." 48 Fed.Reg. 45,766 (1983).

[6]The plaintiffs also argue that if the 60-day periods for Secretarial and judicial review of Board decisions both run from the date of receipt, a provider which received an adverse decision from the Board would have to file suit on the sixtieth day after receiving notice of the Board's

(footnote continued on following page)

B. Collateral Estoppel.

We are not the first to wrestle with the meaning of "is notified" as found in the secretarial review provision of section 1395*oo*(f)(1). In *McCoy v. Harris*, No C77-0389 L(A) (W.D.Ky. Feb. 27, 1980), the court held that the 60-day period for secretarial review begins to run as of the date of the Board's decision. The plaintiffs insist that because this issue was decided against the Secretary in *McCoy*, the Secretary should be collaterally estopped from litigating it here. They point out that *Parklane Hosiery Co. v. Shore*, 439 U.S. 322, 99 S.Ct. 645, 58 L.Ed.2d 552 (1979), has given the federal courts discretion to allow "offensive" use of collateral estoppel, which they maintain is appropriate here.[7]

Subsequent to oral argument in this case, the Supreme Court decided *United States v. Mendoza*, ___ U.S. ___ ,

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decision in order to preserve its appeal rights even though the Secretary might reverse the Board on that date and thereby make judicial review unnecessary. Thus, the plaintiffs argue, if the 60-day period for secretarial reversal began when the Board's decision was rendered, then, 60 days after the provider received notice of this decision, the provider would know whether it was necessary to seek judicial review. This argument assumes that the Board's notice would always be mailed to the provider; if the provider received the Board's decision on the date it was rendered, the provider would face the same dilemma the plaintiffs have described. However, the Secretary's regulation was recently amended to provide that "the Administrator will promptly notify the parties and HCFA whether he or she has decided to review a decision of the Board. . . " 48 Fed.Reg. 45,774 (1983) (to be codified at 42 C.F.R. § 1875(d)(1)).

[7]Offensive use of collateral estoppel occurs when a plaintiff seeks to foreclose a defendant from relitigating an issue the defendant has previously litigated unsuccessfully in another action against the same or a different party. In *Parklane* the Supreme Court upheld the use of collateral estoppel provided that the following conditions are met: (1) the party asserting collateral estoppel could not easily have joined in the action relied on; (2) the party against whom collateral estoppel is being asserted had the incentive to defend the first action vigorously; (3) the judgment relied on is not inconsistent with any previous decisions; and (4) there are no procedural opportunities in the second action which were unavailable in the first action which might be likely to cause a different result. 439 U.S. at 331-32, 99 S.Ct. at 651-52.

104 S.Ct. 568, 78 L.Ed.2d 379 (1984), which held that nonmutual offensive collateral estoppel cannot be used against the government. In *Mendoza*, Mendoza, a Filipino national, filed a petition for naturalization under the Nationality Act of 1940, 8 U.S.C. §§ 1001-1005 (1940 ed. Supp. V). His claim for naturalization was based on the assertion that the government's administration of the Nationality Act denied him due process of law. Neither the district court nor the Court of Appeals for the Ninth Circuit reached the merits of his claim because they held that the government was collaterally estopped from litigating that constitutional issue as a result of an earlier decision brought by other Filipino nationals in another district court. In reversing the Ninth Circuit, the Court held that "*Parklane Hosiery*'s approval of nonmutual offensive collateral estoppel is not to be extended to the United States." *Mendoza, supra*, at ___ - ___, 104 S.Ct. at 571-72. The Court found that "a rule allowing nonmutual collateral estoppel against the government . . . would substantially thwart the development of important questions of law by freezing the first final decision rendered on a particular legal issue. Allowing only one final adjudication would deprive this Court of the benefit it receives from permitting several courts of appeals to explore a difficult question before this Court grants certiorari." *Id.* at ___, 104 S.Ct. at 572 (citations omitted). The Court also noted that "application of nonmutual estoppel against the government would force the government to appeal every adverse decision in order to avoid foreclosing further review." *Id.* Such a rule would tax the government's limited resources and further crowd the dockets of the courts. *Id.* In conclusion the Court said:

> The conduct of government litigation in the courts of the United States is sufficiently different from the conduct of private civil litigation in those courts so that

> what might otherwise be economy interests underlying a broad application of collateral estoppel are outweighed by the constraints which peculiarly affect the government. We think that our conclusion will better allow thorough development of legal doctrine by allowing litigation in multiple forums. Indeed, a contrary result might disserve the economy interests in whose name estoppel is advanced by requiring the government to abandon virtually any exercise of discretion in seeking to review judgments unfavorable to it. The doctrine of res judicata, of course, prevents the government from relitigating the same cause of action against the parties to a prior decision, but beyond that point principles of nonmutual collateral estoppel give way to the policies just stated.

Id. at ___, 104 S.Ct. at 574 (footnote omitted).[8] Thus, we hold that *Mendoza* forecloses the use of nonmutual estoppel against the Secretary here.[9]

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[8]The Court's opinion is not devoid of any ambiguity with regard to the scope of its holding. Even though it states that "*Parklane Hosiery*'s approval of nonmutual collateral estoppel is not to be extended to the United States," *Mendoza*, *supra*, at ___ - ___, 104 S.Ct. at 571, it also says that "nonmutual offensive collateral estoppel . . . does not apply against the government in such a way as to preclude relitigation of issues *such as those involved in this case*," *id.* at ___, 104 S.Ct. at 574 (footnote omitted) (emphasis added). At one point the Court also says that "the United States may not be collaterally estopped *on an issue such as this*. . . ." *Id.* at ___, 104 S.Ct. at 570 (emphasis added). Because we find that the reasons the Court enunciates for its decision apply to all issues, and not just constitutional ones, we find *Mendoza* controlling here.

[9]The Secretary also argues that the *Parklane* prerequisites to use of collateral estoppel have not been satisfied in this instance; namely, that the "judgment relied on," *McCoy*, *supra*, "is not inconsistent with any previous decisions." She cites two cases which she claims are contrary to *McCoy*: *Hospital San Jorge v. Secretary of Health, Educ. and Welfare*, 616 F.2d 580 (1st Cir.1980), and *Villa View Community Hosp., Inc. v. Harris*, Medicare & Medicaid Guide (CCH) ¶ 30,503 (S.D.Cal.1980). Because we have decided that offensive collateral estoppel can not be invoked in this case, it is unnecessary for us to determine whether the above cited cases are inconsistent with *McCoy*.

C. Effective Date of the Deputy Administrator's Decision.

Finally, the plaintiffs contend that, even if the 60 day period for secretarial review begins to run from the date that providers receive notice of the Board's decision, the Secretary's decision was untimely. Although the Deputy Administrator's decision is dated March 6, 1980, it was not mailed until March 11, 1980, 64 days after the date on which the plaintiffs received the Board's decision. The plaintiffs maintain that it was not until this second date, March 11, 1980, that the Deputy Administrator's decision became "effective."

The plaintiffs assert that an agency decision must be placed in the "public domain" before it becomes effective. They cite the Federal Rules of Civil Procedure which require that a judicial decision must first be placed in the public domain before it constitutes a "final judgment."[10] Yet the administrative rules governing the Secretary's review do not require the entry of her decisions in an official docket; hence, we cannot analogize the act determining the appealability of a judicial order to that determining the effectiveness of the Secretary's decision. *See Chem-Haulers, Inc. v. United States*, 536 F.2d 610, 615 (5th Cir.1976); *Statler Distributors v. Alexander*, 148 F.2d 74, 75 (1st Cir.1945). Instead, we must examine the statutory language of section 1395*oo*(f)(1) and the interpretation given by the agency charged with its administration to determine when the Secretary's decision became effective. *Id.* at 613-15.

Section 1395*oo*(f)(1) requires only that the Secretary "reverse, affirm or modify" the Board's decision within

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[10]The plaintiffs cite Fed.R.Civ.P. 58 which provides that "[a] judgment is effective only when . . . entered as provided in Rule 79(a)." Fed.R.Civ.P. 79(a) requires all judgments to be entered in the civil docket.

60 days. There is no additional requirement that the decision must be entered on any docket or mailed within that 60-day review period.[11] The regulation promulgated under section 1395*oo*(f)(1) provides only that the Secretary make her decision within 60 days and that she "promptly" notify the parties of her decision.[12]

In HCFA practice, once a Board decision is received for review, a "master control sheet" is prepared and attached to the file. As the file passes between the Deputy Administrator's Office and the Office of the Attorney-Advisor, this control sheet is signed and dated by those handling the file. In this fashion, a record is kept with regard to what action has been taken on the case. Record Vol. I at 141-43.

When the Deputy Administrator signs his decision, he hand-dates and signs the control sheet accompanying the file. The Secretary's position is that upon this act, her decision becomes "effective." In the instant case, the Deputy Administrator signed and dated both the decision and the control sheet on March 6, 1980, 59 days after the plaintiffs received the Board's decision. Thus, the Secretary maintains her decision was timely.

It is established that interpretations of a statute by the agency charged with its administration should weigh heavily absent a compelling reason to the contrary. *See, e.g., Red Lion Broadcasting Co. v. F.C.C.*, 395 U.S. 367, 381, 89 S.Ct. 1794, 1801, 23 L.Ed.2d 371 (1969). This is not the precise situation before us, but we are persuaded that the Secretary's interpretation of section 1395*oo*(f)(1) is similarly entitled to some deference, especially where there is

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[11]The legislative history of section 1395*oo*(f)(1) does not give any guidance as to when the Secretary's decision becomes effective.

[12]See note 5, *supra*.

no compelling precedent[13] or reason tending to support an opposite view.[14] *See Chem-Haulers, Inc. v. United States*, 536 F.2d at 615. We hold, therefore, that the Secretary's decision became effective on March 6, 1980, and that her reversal of the Board's decision was timely.[15]

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[13]There is little case law on this issue. In *Statler Distribs. v. Alexander*, 148 F.2d 74 (1st Cir.1945), the court held that the agency's decision was "entered" only when signed and placed in the agency's files as a complete act and when a copy of the order was received by the petitioner. In *Amodio v. Reconstr. Fin. Corp.*, 191 F.2d 862 (Emer.Ct.App.1951), the agency's order became effective on the date entered, not when received by the claimant. In *Braniff Airways, Inc. v. Civil Aeronautics Bld.*, 379 F.2d 453 (D.C.Cir.1967), the court held that a Civil Aeronautics Board order became valid when it was adopted and entered, not when it was received by the parties. Finally, in *Chem-Haulers, Inc. v. United States*, 536 F.2d 610 (5th Cir.1976), we held that Interstate Commerce Commission orders are "entered" when the Commission's seal and the Secretary's signature are affixed to the order.

Each of these cases demonstrate only that the time at which an agency decision becomes final can be determined only through an examination of the statutes and regulations under which that agency operates.

[14]The plaintiffs urge us to hold that the Secretary's decision does not become effective until it is mailed to prevent the Deputy Administrator from backdating his decisions. They allege that in *Humana, Inc. v. Califano*, Nos. 78-0584 and 78-0175 (D.D.C.1979), and *McCoy v. Califano*, No. C77-0389 L(A) (W.D.Ky. Feb. 27, 1980), the Secretary's delegate signed backdated decisions in order to create the appearance of meeting the 60-day time limit. This has, the plaintiffs claim, seriously compromised the integrity of the review process, and thus necessitates a "prophylactic" rule. The Secretary denies the plaintiffs' claim, but notes that the procedures in effect at the time of the decisions in the *McCoy* and *Humana* cases were later changed and were not the same procedures that existed at the time of the administrative review in this case. In any event, we decline to adopt such a prophylactic rule as the plaintiffs urge us to do.

[15]The plaintiffs also argue that, since the Secretary is to "promptly" notify the provider of the result of the review, *see* note 5, *supra*, it is reasonable to interpret "promptly" to mean on the day the decision is signed. They note that, in this case, the Secretary's decision was not mailed for five days after it was signed and dated. While the plaintiffs may have wished to have been more "promptly" informed of the Secretary's decision, the Secretary advanced plausible reasons for this five day delay in mailing the decision, and we do not believe her decision was untimely for this reason.

III. SCOPE OF JUDICIAL REVIEW.

Plaintiffs sought judicial review of the Secretary's decision pursuant to 42 U.S.C. § 1395*oo*(f); this section requires us to apply the standard of review applicable to actions arising under the Administrative Procedure Act. Our review is limited to determining whether the agency action was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. . . ." 5 U.S.C. § 706(2)(A) (1976).

The Medicare program is structured around the concept of reasonable cost. Under that concept, a provider is to be reimbursed only for the reasonable cost of providing medical services to Medicare beneficiaries. The Medicare statute sets forth only the broadest definitional parameters, requiring reasonable cost to be

> [T]he cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services. . . .

42 U.S.C. § 1395x(v)(1)(A). Beyond this threshold requirement, reasonable cost is to be determined under regulations promulgated by the Secretary "establishing the method or methods to be used, and the items to be included, in determining such costs. . . ." *Id.* These regulations must, however, take into account the direct and indirect costs necessary in the efficient delivery of covered services to Medicare beneficiaries so that such costs will not be borne by non-covered individuals. Conversely, the cost of rendering services to non-covered individuals is not to be borne by the Medicare program.

Pursuant to this statutory authority, the Secretary has promulgated regulations to reimburse providers for their reasonable costs incurred in rendering medical services to

Medicare beneficiaries.[16] 42 C.F.R. §§ 405.401-488. At issue in this case is whether certain costs and returns on equity capital claimed by the plaintiffs are allowable under those regulations or the Medicare statute itself. The validity of the Secretary's regulations "will be sustained so long as [they are] 'reasonably related to the purposes of the enabling legislation'. . . ." *Mourning v. Family Publications Serv., Inc.*, 411 U.S. 356, 369, 93 S.Ct. 1652, 1660, 36 L.Ed.2d 318 (1973) (quoting *Thorpe v. Housing Authority of Durham*, 393 U.S. 268, 280-81, 89 S.Ct. 518, 525, 21 L.Ed.2d 474 (1969)). See also *Springdale Convalescent Center v. Mathews*, 545 F.2d 943, 951 (5th Cir.1977); *Florida v. Mathews*, 526 F.2d 319, 323-24 (5th Cir.1976). Because the Secretary's interpretation of "reasonable costs" is entitled to "considerable deference," *Springdale Convalescent Center v. Mathews, supra*, at 951, the plaintiffs here have the "difficult burden" of proving that the Secretary's interpretation conflicts with the statutory scheme. *Id.* We note, however, that the Secretary's discretion "is not unfettered," and "[e]ach cost reimbursement regulation must approximate as closely as is practicable the direct and indirect costs of rendering services only to persons covered by the Act." *Id.* at 952 (citations omitted).

Thus, our review is a narrow one. The agency decision must be upheld as long as there is a rational basis for the Secretary's interpretation of the statute and the regulations. *Homan & Crimen, Inc. v. Harris*, 626 F.2d 1201, 1211

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[16]The Secretary's interpretation of these statutory and regulatory provisions is contained in a manual which has been distributed to fiscal intermediaries. The rulings contained in this "Provider Reimbursement Manual," while without the force of law, are entitled to be given important significance. *See Humana of Kentucky, Inc. v. Harris*, CCH Medicare and Medicaid Guide ¶ 31,610 (W.D.Ky.1981) (discussion of controlling weight of the Secretary's interpretations as contained in the Provider Reimbursement Manual).

(5th Cir.1980), *cert. denied*, 450 U.S. 975, 101 S.Ct. 1506, 67 L.Ed.2d 809 (1981); *State of Florida v. Mathews*, *supra*, at 324-25.

The plaintiffs, however, suggest that we abandon the normal rule of deference in this case because the Board's decision differed in substantial part from the Secretary's final decision. The plaintiffs note that the members of the Board are required to be persons knowledgeable in this field, 42 U.S.C. § 1395*oo*(h), and that their decisions are final absent review by the Secretary. We have held, however, that the decision of the Board carries "no more weight on review by the Secretary than any other interim decision made along the way in an agency where the ultimate decision of the agency is controlling." *Homan & Crimen, Inc. v. Harris*, 626 F.2d at 1205. To this we added: "[t]he argument that the court should recognize the expertise of the members of the [Board] must be met with the assumption that those persons within the agency who assisted the Secretary in a contrary decision must be regarded as being equally expert."[17] *Id.*

IV. THE MERITS.

A. Stock Maintenance Costs.

During 1973, HCA incurred over $185,000 in expenses referred to by the Secretary as "stock maintenance costs." These costs consisted of (1) stock transfer and registration

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[17]The plaintiffs also assert that the Secretary's decision in this case is not entitled to deference because the Deputy Administrator did not personally consider the evidence. They also claim that the Deputy Administrator's decision conflicts with prior agency policy and that the review process is biased. We find none of these arguments to be persuasive. We note, however, that with regard to the first allegation: " '[T]he broad ideal that agency heads should do personally what they purport to do is for many functions impractical and unworkable.' The use of assistants in the administrative process is indispensable to the orderly and efficient expedition of great volumes of work. . . ." *Braniff Airways, Inc. v. Civil Aeronautics Bd.*, 379 F.2d 453, 461 (D.C.Cir. 1967) (quoting 2 Davis, *Administrative Law* § 11.07, at 66 (1958)).

fees; (2) reports to stockholders; (3) stockholders' meetings; (4) legal and accounting fees incurred through SEC filings and stockholders' meetings; and (5) public relations aimed at institutional investors. HCA claimed these expenses on its 1973 cost report, but the Secretary disallowed them because she found these costs were incurred primarily for the benefit of HCA's stockholders. The Secretary also held that these costs were not related to actual patient care or necessary to the rendition of patient care services. Therefore, she concluded, these costs could not properly be allocated from HCA to its member hospitals for Medicare reimbursement. The district court reversed the Secretary's decision, finding her denial of these costs "to be arbitrary and capricious, and contrary to law." Although the district court advances several strong arguments in opposition to the Secretary's position, we do not believe that the Secretary's interpretation is irrational or unreasonable. Thus, we must reverse the judgment of the district court on this claim.

The Medicare program reimburses a provider's costs only if they are not "unnecessary in the efficient delivery of needed health services. . . ." 42 U.S.C. § 1395x(v)(1)(A). The issue here is whether stock maintenance costs are included in this definition. Shortly after the Medicare program began, the Secretary determined that stock maintenance expenses, while ordinary business expenses, were only tangentially related to the care of beneficiaries. Thus, they were not reimbursable.[18]

In making this determination, the Secretary focused on the primary purpose underlying each cost to determine

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[18] In January, 1973, the Secretary promulgated this policy in Provider Reimbursement Manual § 2150.2B.1.; in August, 1973, it was reemphasized in Provider Reimbursement Manual § 2134.9.

whether there exists a sufficient nexus to patient care.[19] By using this method, the Secretary decided that stock maintenance costs are incurred primarily to render investment-related services to corporate shareholders, not patient care services to Medicare beneficiaries. For example, the Secretary notes, SEC filings are designed to ensure that investors have available adequate information in order to decide whether to buy, sell or hold a registrant's securities.[20] Annual meetings and reports provide existing and prospective shareholders with information concerning the corporation's financial condition and profitability.[21] These meetings also provide a forum in which stockholders can vote on resolutions affecting the corporation's profit-making activities and can elect directors who they believe will better guide the company in its financial operations. Stock transfer and registration fees facilitate sales of stock and provide the corporation with an orderly record of stock ownership, an expense primarily of benefit to stockholders. Finally, public relations directed at institutional buyers benefit corporate stockholders in so far as increased institutional purchases raise the price of their shares. Thus, the Secretary argues, stock maintenance costs are only incidentally related to health care.

The plaintiffs counter by insisting that a corporate provider must incur most of these costs in order to render

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[19]The Secretary notes that her focus on the costs' primary purpose is quite similar to the use of a primary purpose test to determine whether an expense qualifies as a business expense deductible under 26 U.S.C. § 162 (1976 & Supp. V 1981). *See* 26 C.F.R. § 1.162-2(b)(1) (1982).

[20]These filings also protect the interests of prospective shareholders by providing them with the complete picture of a corporation's financial condition before purchasing stock.

[21]The Secretary also notes that annual reports serve the additional end of "selling" the company to prospective investors.

medical services.[22] The plaintiffs point out that, in order for a corporation to function, it must hold meetings to elect directors, must distribute reports to shareholders, must incur stock transfer fees, and must incur legal and accounting fees in connection with SEC requirements. The plaintiffs, however, fail to make the critical distinction between costs that are necessary for the maintenance of a corporate structure and those that are necessary for providing medical services. *See American Medical International, Inc. v. Secretary of Health, Education and Welfare*, 466 F.Supp. 605, 612-13 (D.D.C.1979), *aff'd*, 677 F.2d 118 (D.C.Cir.1981). While stock maintenance costs may be ordinary and necessary business expenditures of a corporate provider, this consideration is not controlling. The costs must be necessary to the furnishing of medical care. *Id.* Of course, some of the activities that give rise to stock maintenance costs are required by law. But those legal requirements are imposed solely to ensure that corporations are accountable to their current and prospective stockholders. They have no connection to Medicare services. Furthermore, as the Secretary notes, although HCA may be legally required to incur some of these costs to maintain its corporate status, this is a consequence of HCA's election to organize as a publicly-held corporation. Obviously, medical care can be furnished by non-corporate entities; therefore medical care can be rendered without incurring these disputed costs.[23]

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[22]The Medicare regulations expressly recognize that corporations may participate as Medicare providers. 42 C.F.R. §§ 405.402(b)(5) and 405.429(a)(2).

[23]The decision in *American Medical Int'l* also properly disposes of another argument made by the plaintiffs in this case:

> Similarly, the primary purpose test answers plaintiffs' challenge to the Secretary's decision to reimburse certain costs of corporate organizing incident to the creation of the entity, while denying reimbursement for stock maintenance costs. The primary purpose of all costs incurred at the creation of the entity is to bring into existence a provider of medical services. As the entity survives, the stock maintenance costs have as their primary purpose the protection of stockholder interests in investment. This is a rational distinction justifying the different treatment accorded the different costs by the Secretary.

466 F.Supp. at 615.

In reversing the Secretary's disallowance of the stock maintenance costs, the district court relied heavily upon the Court of Claims' decision in *AMI-Chanco, Inc. v. United States*, 576 F.2d 320 (Ct.Cl.1978). In *AMI-Chanco*, the court recognized that stock maintenance costs are largely incurred for the benefit of stockholders. However, the court gave conclusive weight to the fact that corporate providers are legally required to incur these costs, and held the Secretary's disallowance of these costs to be arbitrary and capricious.[24] We differ with the Court of Claims because we do not believe that the "primary purpose" test the Secretary utilizes here is unreasonable or irrational. Furthermore, we agree with the Secretary's position that even necessary business expenses must also be necessary to patient care in order to be reimbursed under Medicare. Although the *AMI-Chanco* court advanced other grounds for its decision that we could mention here, we prefer to address them indirectly through our discussion of the district court's opinion.

The district court held that the disallowance of stockholder maintenance costs conflicts with the Medicare regulation that prohibits inequitable treatment of proprietary and non-proprietary hospitals. *See* 42 C.F.R. § 405.402(b)(5). The court found that it is inconsistent for the Secretary to reimburse similar costs incurred by non-profit corporations, while denying such reimbursement to profit corporations. Yet "the purpose of annual meetings, filings, etc., of non-profit corporations is not for investment but, rather, to further the goal of providing improved medical care. On the other hand, the *primary* purpose of annual meetings, filings, etc., of profit corporations is to enhance investments." *American Medical International, Inc. v. Sec-*

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[24]In *AMI-Chanco*, no public relations expenses were claimed—which, of course, are not required by law.

retary of Health, Education and Welfare, 466 F.Supp. at 615 (emphasis in original). Of course, certain activities occurring at the profit corporation's annual meeting may relate to providing medical care. *Id.* But separating reimbursable costs from those that are not may require the Secretary to draw fine lines. "The problems of government are practical ones and may justify, if they do not require, rough accommodations. . . ." *Weinberger v. Salfi*, 422 U.S. 749, 769, 95 S.Ct. 2457, 2468, 45 L.Ed.2d 522 (1975). Consequently, we find the "primary purpose" test used by the Secretary to be reasonable and justifies the disparate treatment of profit and non-profit corporations. *American Medical International, supra*, at 615.

The district court also held that disallowing stock maintenance costs will cause necessary costs of rendering services to Medicare beneficiaries to be borne by non-Medicare patients in violation of 42 U.S.C. § 1395x(v)(1)(A). The fallacy in this argument is that the statute only refers to the necessary costs of rendering services; stock maintenance costs, as we have shown, fall outside this category.

Finally, the district court noted that HCA's stock maintenance costs are recognized as general and administrative expenses under generally accepted accounting principles. According to the court, to disallow these costs would be contrary to 42 C.F.R. § 405.406, which requires generally accepted accounting principles to be applied in determining reasonable costs.[25] Section 405.406, however, "only pro-

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[25]The district court explained: "The accounting profession does not recognize a separate category of 'stock management costs.' Neither do other federal agencies, which consider these costs simply part of the ordinary and necessary expenses of corporate business." Record Vol. I at 39. The fact that other government agencies may allow stock maintenance costs is not determinative as to whether Medicare must reimburse those costs. Medicare does not reimburse all business expenses, but only those that are reasonably related to patient care. 42 U.S.C. § 1395x(v)(1)(A). "Accounting and legal principles appropriate in other contexts for other purposes have little persuasive force here because the question before us must be according to the Medicare regulations and the policies those regulations were designed to implement." *Richey Manor, Inc. v. Schweiker*, 684 F.2d 130, 135 (D.C.Cir.1982). *Accord Gosman v. United States*, 573 F.2d 31, 46 n. 16 (Ct.Cl.1978).

vides that accepted accounting principles be used in uniform record-keeping, not in determining costs allowable under the Medicare Act. The regulations is directed at the type of financial data and reports required of providers; it is not a regulation affecting the substantive provisions of the program as to what constitutes reimbursable costs." *American Medical International*, 466 F.Supp. at 623.[26]

The plaintiffs offer additional grounds in support of the district court's decision. The first relates to employee stock options. During 1973 HCA had three employee stock option

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[26]The district court also held that these costs should be reimbursed so as not to contradict the Medicare policy that corporate providers should be allowed to attract and keep equity capital to maintain their Medicare services. Section 1395x(v)(1)(B) of the Medicare Act provides for a return on investment and the regulation adopted pursuant to the provision explains:

> Proprietary providers generally do not receive public contributions and assistance of Federal and other governmental programs in financing capital expenditures. Proprietary institutions historically have financed capital expenditures through funds invested by owners in the expectation of earning a return. A return on investment, therefore, is needed to avoid withdrawal of capital and to attract additional capital needed for expansion.

42 C.F.R. § 405.429(b)(1). The district court held that disallowance of the stock maintenance costs would contradict this principle; in support the court cited *AMI-Chanco v. United States*, *supra*, where that court held:

> By directing that corporate providers shall receive a reasonable return on equity capital, Congress has declared that it considers a reasonable return on investment to be one of the costs of patient care which is reimbursable under the Act. Surely, if Congress meant to bolster the effectiveness of the Medicare program by offering the incentive of a return on equity to investors of capital, it also intended to provide reimbursement for stock maintenance costs, which by their very definition are essential elements of the process of attracting the equity capital necessary to provide patient care services. In fact, it is a contradictory policy which encourages the attraction of investment capital but disallows the costs of doing so, on the grounds that the latter costs are not related to patient care.

576 F.2d at 324. We believe that this argument is flawed for the reasons carefully drawn by the court in *American Medical Int'l*, 466 F.Supp. at 613-14, which we do not reiterate here.

plans. In order to implement these plans, HCA was required to incur many of the costs at issue. Stockholders' meetings were held to adopt each of the stock option plans and to amend such plans; registration statements were filed in connection with the options issued; and SEC filing requirements were a necessary cost of such plans. The plaintiffs note that the Secretary has determined that employee fringe benefits are allowable costs. Provider Reimbursement Manual §§ 2144.1-2144.4.[27] They note further that Medicare allows reimbursement of all of the costs associated with the company's stock option plans except for stock maintenance costs. Thus, they argue, because stock maintenance costs are required to implement HCA's stock option plans, there is no logical basis for disallowing them. In reply, the Secretary points out that the plaintiffs have received reimbursement for that portion of stock maintenance costs related to its employee stock option plans. This amount was paid because the Secretary believes that fringe benefits, like most other forms of employee compensation, are related to patient care. The remainder of the costs, she has determined, are related primarily to benefiting HCA's stockholders and, consequently, cannot be reimbursed.

Finally, the plaintiffs contend that the Secretary's reimbursement of interest expense and other costs incurred through debt is inconsistent with her disallowance of stock maintenance costs. Interest expense, along with other finance charges, is a reimbursable cost when the borrowed funds are used by a provider to render health care. The plaintiffs assert that stock maintenance costs are simply an spect of equity financing. Thus, they conclude, it is unreasonable to reimburse debt expense and deny reimbursement of stock maintenance costs. We disagree. Interest on debts

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[27]The Provider Reimbursement Manual is discussed at note 16, *supra*.

used solely for funding patient care facilities is primarily incurred for providing medical care. Debts not so used are not reimbursable.[28] To the extent that stock maintenance costs "may benefit medical services by assisting in the attraction of equity capital, this effect is too incidental to override the fact that the primary purpose of stock maintenance costs is to enhance investment." *American Medical International, supra*, at 615 (emphasis omitted).[29]

In conclusion, we recognize that the plaintiffs have advanced strong arguments favoring the reimbursement of stock maintenance costs, but our review is limited to whether the Secretary's decision denying these costs is "arbitrary" or "capricious." We do not find that the Secretary's decision is irrational or inconsistent with the purpose of the enabling legislation. *See, e.g., State of Florida v. Mathews*, 526 F.2d at 323.[30] Thus, the judgment against the Secretary is reversed.

B. Return on Equity in Goodwill.

During 1958 and 1969, HCA acquired 100% of the stock of nine hospital corporations. The purchase price of the hospitals included goodwill, defined by Medicare as the excess of the price paid to acquire a hospital over the fair market value of the hospital's tangible assets. Total goodwill from these nine acquisitions equalled $21,983,554.

Following each acquisition, HCA assumed complete management and control over the hospital's operation, installed new management and negotiated new contracts. Yet

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[28]*See* 42 C.F.R. § 405.419.

[29]The remaining arguments plaintiffs raise in their briefs which we have not specifically addressed are less supportive of their position and have been amply replied to by the Secretary. Thus, we do not believe they warrant any discussion here.

[30]We note that our result is in accord with that reached by the D.C. Circuit. *See American Medical Int'l v. Secretary of Health, Educ. and Welfare*, 677 F.2d 118 (D.C.Cir.1981).

none of the acquired hospitals was subsequently dissolved by, or merged with, HCA. Rather, each continued to operate as a separate corporate entity. Moreover, none of the assets of the acquired hospitals was subsequently distributed to HCA. Instead, the assets continued to be held by the acquired corporations.

In 1973, HCA included the goodwill obtained in the purchase of the nine hospital corporations in establishing a value for its equity capital. HCA then used this value in determining its Medicare reimbursement claim for return on equity. This claim was denied by the Secretary. She notes that Medicare pays proprietary providers a "reasonable return on equity capital . . . invested in the facility and used in the furnishing of . . . services . . . ." 42 U.S.C. § 1395x(v)(1)(B). "Equity capital" is defined as the "provider's investment in *plant, property*, and *equipment* related to patient care . . . ." as well as net working capital maintained for the operation of patient care services. 42 C.F.R. § 405.429(b)(1)(i) (emphasis added). The regulations also provide that investment in facilities is to be recognized on the basis of the "historical cost" used for depreciation. 42 C.F.R. § 405.429(b)(ii). "Historical cost," in turn, is defined as the "cost incurred by the present owner in acquiring the *asset*." 42 C.F.R. § 405.415(b)(1) (emphasis added). Thus, under the regulations, return on equity capital may be paid only to the extent there is an investment in plant, property or equipment (i.e., assets). Furthermore, the investment must be that of the provider. In each of its nine acquisitions, HCA purchased only stock. Because the purchases of the acquired hospitals' stock did not equate to a purchase of their assets, the nine hospital corporations continued to own the hospital facilities and continued as the "providers" of medical services. Thus, the Secretary says, HCA was not entitled to receive a return on equity capital.

Only the individual hospital corporations, as providers, were qualified to make a claim. Their right to return on equity, however, was limited to their investment in plant, property, and equipment and to their net working capital. The price HCA paid for the corporate stock, and the goodwill which was shown on HCA's books, could not be claimed because those items did not reflect the "provider's investment." Following each of HCA's nine acquisitions, the "present owner" of the "assets" was the provider, and the cost which the provider incurred in acquiring the assets did not include the "goodwill" which HCA claimed. Consequently, HCA's reimbursement claim was denied.

The plaintiffs point out that denial of reimbursement here draws an arbitrary distinction between stock acquisitions, where a return on goodwill is denied, and statutory mergers, where it is allowed.[31] We disagree. It is an elementary principle of corporate law that a corporation and its stockholders are separate entities and that the title to corporate property is vested in the corporation and not in the owners of the corporate stock. *Moline Properties, Inc. v. Commissioner*, 319 U.S. 436, 63 S.Ct. 1132, 87 L.Ed. 1499 (1943). When there is a statutory merger, a new "provider" is created and ownership of the facility changes hands. Thus, Medicare will pay an increased return on equity capital based on the fact that the corporate assets have been transferred to a new provider and have a new "historical cost" upon which the

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[31]We note that, under 42 C.F.R. § 405.429(b)(2), the Secretary excludes from equity capital goodwill purchased in acquisitions effected after July 1970. However, goodwill purchased in connection with hospital assets and facilities prior to that date can be included in the provider's equity capital for the purposes of computing a return on investment. 42 C.F.R. § 405(b)(3). Because HCA's purchase of the goodwill at issue was effected prior to 1970, it included this goodwill in its 1973 cost year as part of its equity capital. Thus, our inquiry is limited to whether goodwill purchased through 100% stock acquisitions prior to July 1970 should be includable in equity capital.

return is calculated and paid. However, in stock purchases of providers, ownership of the corporate assets remains in the hands of the original provider whose equity capital is limited to the assets' original historical cost.[32]

Our decision in *Homan & Crimen, Inc. v. Harris*, 626 F.2d 1201 (5thCir.1980), *cert. denied*, 450 U.S. 975, 101 S.Ct. 1506, 67 L.Ed.2d 809 (1981), is controlling here. In *Homan*, Medenco, Inc., through a wholly owned subsidiary, purchased 100% of the stock of Homan & Crimen, Inc., a corporation doing business as Southwestern General Hospital. Immediately following the purchase, Medenco assumed complete management and control over the operation of the hospital. However, Homan & Crimen, Inc., was never liquidated[33] and continued as the owner of the hospital facility. Subsequently, Homan & Crimen d/b/a Southwestern General Hospital submitted Medicare cost reports for the 1972 and 1973 fiscal years, claiming a return on equity capital for the amount by which the price paid by Medenco exceeded the net book value of the hospital assets. Homan & Crimen's claim was disallowed by the Secretary. In upholding the Secretary's decision, we held that Medenco's 100% stock acquisition of Homan & Crimen was not a purchase of its assets. Thus, Homan & Crimen, not Medenco, was the owner of the hospital facility and continued as the provider. In conclusion we said:

> [E]quity capital upon which a return may be based must be the provider's and it must be related to patient care.

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[32]The distinction drawn between stock purchases and statutory mergers is set forth in 42 C.F.R. § 405.415(*l*).

[33]The significance of non-liquidation lies in the fact that where a Medicare provider acquires 100% of the stock of another corporate provider and shortly thereafter liquidates the acquired company, these two steps have been viewed as a purchase of assets and goodwill can be computed as part of the purchaser's equity capital. *See, e.g., Pacific Coast Medical Enter. v. Harris*, 633 F.2d 123 (9th Cir.1980).

> In view of our holding that Homan & Crimen is the provider because its separate identity should not be disregarded and that Medenco's investment in Homan & Crimen stock was not an investment related to patient care, it follows that plaintiffs are not entitled to a return on the purchase price of stock.

626 F.2d at 1210.

Therefore, in light of *Homan*, it is clear that the goodwill HCA purchased through the 100% stock acquisitions can not be considered as part of HCA's equity capital upon which a return may be claimed. *See also American Medical International, supra*; *Monterey Life Systems v. United States*, 635 F.2d 821 (Ct.Cl.1980).

The plaintiffs argue that section 1214 of the Provider Reimbursement Manual expressly allows goodwill purchased in pre-1970 transactions to be included in the return on equity capital computation. Section 1214 provides in pertinent part:

> Goodwill purchased in an acquisition prior to August 1970 of an existing organization is includable in the provider's equity capital. The amount of goodwill is determined in accordance with generally accepted accounting principles.

The manual provision, according to the plaintiffs, does not require the purchase of a "facility" or "assets," but rather requires only the acquisition of an "existing organization." Thus, since the nine hospital corporations acquired by HCA through 100% stock purchases were "existing organizations," it is entitled to a return on this goodwill.

We believe that the word "organization" as used in section 1214 must be read in conjunction with the language of section 1395x(v)(1)(B) and 42 C.F.R. § 405.429, which govern the payment of return on equity. Section 1395x(v)(1)(B) refers to equity capital as that capital in-

vested in a "facility," and section 405.429 interprets the word "facility," to mean "plant, property, and equipment." The regulation also provides that a provider's "investment in facilities" is to be recognized on the basis of "historical cost," which, in turn, is defined as the cost incurred by the present provider in acquiring the "asset."[34]

Thus, we find that the Secretary's disallowance of reimbursement for equity capital based on goodwill to be reasonable and affirm the district court on this issue.

C. Costs of Unconsummated Acquisitions.

The next issue also arises from HCA's acquisition program. In 1973, HCA evaluated several hospitals for possible acquisition, ultimately purchasing some but deciding not to accquire others. The costs incurred in making these evaluations were claimed on HCA's home office cost report and allocated to the individual providers operated by HCA (all of which are plaintiffs in this suit). The plaintiffs' fiscal intermediaries allowed Medicare reimbursement for the costs incurred in evaluating the facilities which were actually purchased. However, they denied Medicare reimbursement for the costs incurred in investigating the facilities which were not purchased.[35] In ultimately disallowing these costs, the Secretary noted that HCA is a chain organization engaged in the business of acquiring hospitals so as to increase corporate profits. While Medicare reimburses a provider's

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[34]HCA also argues that § 1214 requires the Secretary to apply generally accepted accounting principles in determining whether or not goodwill is includable in the return on equity capital computation. We find that the second sentence of § 1214 requires only that, if a return on equity is to be paid for goodwill, the *amount* of goodwill must be determined in accordance with generally accepted accounting principles.

[35]The parties stipulated that the amount of disallowed costs was $87,802; Medicare's reimbursement, if allowed, would be approximately $26,000.

reasonable costs, it does not reimburse the costs of seeking additional earnings to the extent that those costs are unrelated to patient care. Here, she held, no patient care services resulted from the unconsummated acquisition costs and, consequently, reimbursement of those costs had to be denied.

The plaintiffs advance several arguments in opposition to the Secretary's decision not to reimburse unconsummated accquisition costs, most of which can be dealt with summarily. First, they argue that HCA's acquisition program enabled it to lower health care costs. By acquiring more member hospitals, HCA was able to buy more items in bulk and was able to spread fixed costs over a greater number of units. While the costs incurred in investigating unacquired hospitals did not in themselves result in economies of scale (in that they did not result in additional member hospitals), these expenses were an unavoidable cost of the acquisition program which did effect successful acquisitions. The plaintiffs cite 42 C.F.R. § 405.451(a), which requires the reimbursement of all "necessary and proper" costs, and they assert that these unconsummated acquisition costs were both necessary and proper. Section 405.451(a), however, permits the payment of necessary and proper costs only if they are "*incurred in rendering the services [covered under the Medicare Act and related to the care of beneficiaries]*." (Emphasis added.) Since the acquisitions here were never consummated, the costs were never "incurred in rendering, . . . services," and never became related to the care of beneficiaries. Furthermore, we agree with the Secretary's position that these costs are too remotely related to the provision of health care to allow them to be considered reasonable costs. The plaintiffs' argument is similar to that raised and rejected by the court in *Gosman v. United States*, 573 F.2d 31 (Ct.Cl.1978). In *Gosman*, the plaintiffs sought reimbursement for advertising and public relation expenses

designed to increase the occupancy of a group of nursing homes. The plaintiffs there claimed that by increasing the occupancy rate, the per diem cost of caring for Medicare beneficiaries would be lower, thus benefiting the program. This argument was rejected by the court, which held that the Medicare Act and its regulations preclude the reimbursement of "indirect expenditures only tangentially or speculatively related to the actual care of Medicare beneficiaries." *Id.* at 38. *See also American Medical International v. Secretary of Health, Educ. & Welfare*, 466 F.Supp. at 613 n. 3 (fact that stock maintenance costs allow equity capital and thus reduces reimbursable finance costs incurred through debt too attentuated to justify reimbursement).

Nonetheless, the plaintiffs cite section 1395x(v)(1)(A), which requires Medicare to "pay its own way" so that the costs of delivering care to patients covered by Medicare "will not be borne by individuals not so covered . . . ." Thus, they argue that, if these unsuccessful acquisition costs are not reimbursed by Medicare, they will be borne in their entirety by non-Medicare patients, notwithstanding the benefit realized by Medicare from these costs. As previously noted, unconsummated acquisition costs are not necessary costs of covered services and, as a result, do not fall within the cost-shifting prohibition. Indeed, if HCA's cost-shifting argument were to prevail, "no cost could ever be disallowed for reimbursement purposes because to do so would tend to shift the cost to non-Medicare patients." *Pasadena Hosp. Association v. United States*, 618 F.2d 728, 735 (Ct.Cl.1980).

The plaintiffs also seek support from 42 C.F.R. § 405.429, the return on equity capital regulation, and from 42 C.F.R. § 405.402(b)(6), which states that there should be "recognition of the need of hospitals . . . to make improvements." Neither provision requires reversal of the Secre-

tary's determination. As the Secretary explains, section 405.429 "does not magically transform all expansion expenses, including those connected with unsuccessful ventures, into reimbursable costs. If that were the effect, virtually all expenses . . . would be reimbursable without regard to their relationship to patient care." Brief for Appellee/Cross-Appellant at 57-58. Similarly, the general policy of section 405.402(b)(6), which recognizes the need for hospitals to make improvements, is inapposite here. The hospitals being investigated were not acquired and, consequently, no improvements were made and no patients were benefited.

Finally, the plaintiffs argue that the Secretary's disallowance of HCA's unconsummated acquisition costs is contrary to Medicare's treatment of other home office costs. A number of home office management decisions result in abandoned efforts, the costs of which are not challenged by Medicare. These include costs associated with investigating computer installations, shared services, litigation and personnel recruitment. The Secretary distinguishes reimbursement of these costs on the ground that these expenses are more closely related to the improvement or maintenance of health care services provided by existing facilities. In contrast, the Secretary argues, HCA's acquisition program was directed primarily at establishing itself as a "growth industry" among potential stockholders. In order to obtain more investors, HCA needed to expand by purchasing additional profitable hospitals. She argues that the primary purpose of HCA's unconsummated acquisition costs was to prevent HCA from making financially disadvantageous acquisitions, which might deplete corporate resources and lower corporate profits. Thus, she concludes, the principal benefit of these costs was felt by HCA and its stockholders, not HCA's Medicare patients, and to reimburse these costs would

be inappropriate. Although the Secretary has drawn a fine line here, we do not find the distinction she makes to be irrational. As the Fourth Circuit noted in *Fairfax Hosp. Association v. Califano*, 585 F.2d 602, 606 (4th Cir.1978):

> Particularly in a program as complex as the Medicare program, with its large number of providers and suppliers . . . the Secretary in his regulations may make, indeed he must make, "rough accommodations . . ." using generalized classifications governing the methods of calculating "reasonable cost" when it is obvious that individualized cost calculations are both not administratively practical and unduly expensive.

See also American Hospital Management Corp. v. Harris, 638 F.2d 1208, 1212 & n. 7 (9th Cir.1981). Thus, we affirm the district court on this issue.

D. Capitalization of Return on Equity in Aircraft.

The final issue we must contend with requires us to draw a distinction between reimbursement for necessary and proper costs of patient care and payment of a return on equity capital invested in hospital facilities. During 1973 HCA owned three aircraft which it used for current hospital operations, construction of new hospitals, and carrying out its acquisition activities. The issue here is whether to the extent the aircraft were used for construction and acquisition activities, a return on equity may be capitalized and added to the historical cost of the new facilities constructed.

The plaintiffs' contentions can best be explained through the use of an example: Suppose that HCA had invested $100,000 in an airplane with a useful life of 10 years and that it used the airplane for current hospital operations 75% of the time, and for hospital construction activities 25% of the time. Assume further that the airplane is in its third year of operation, that the return on equity paid by Medicare that

year is 10%, and that the airplane is depreciated on a straightline basis.

Medicare would allow $7,500 ($100,000 × 75% × 1/10)[36] in depreciation for that portion of the aircraft used for current operations. Moreover, for that part of the aircraft used in construction activities, HCA would be allowed to capitalize depreciation of $2,500 ($100,000 × 25% × 1/10) and add this amount to the historical cost of the completed facilities to be reimbursed over a gradual basis.

HCA would also be paid a return on net equity for that portion of the aircraft used for current operations. HCA's net equity in the aircraft by the third year would be $80,000 ($100,000 original investment minus two years depreciation of $20,000—$7,500 per year attributed to current operations, and $2,500 per year attributed to construction operations). Thus, HCA's return would equal $6,000 ($80,000 [net equity] × 10% [rate of return] × 75% [time used for current operations]).

At issue here is whether HCA should be allowed to compute a return on equity for that portion of the aircraft used in construction activities, and then add that amount to the historical cost of the completed facilities. If so, then HCA would be allowed to capitalize a current return on equity of $2,000 ($80,000 [net equity] × 10% [rate of return] × 25% [time used for construction activities]).

HCA's fiscal intermediaries would not allow such a return, whether capitalized or not. The plaintiffs argue, however, that the applicable Medicare statute and regulations authorize HCA to capitalize a return on equity in the aircraft during the time it was used for construction. They note that the "historical cost" of a facility (upon which a return on

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[36]This assumes that the airplane has a zero salvage at the end of its useful life.

equity capital is based) is defined in 42 C.F.R. § 405.415(b) as "the *cost* incurred in acquiring the asset." (Emphasis added.) Because, they contend, a return on equity capital is a "reasonable cost" under Medicare, this "cost" must be added to the "historical cost" of the buildings under construction. The Secretary contends, on the other hand, that the intermediaries properly disallowed the capitalization of such a return because return on equity capital is not a "cost." Thus, the crux of this issue is whether a return on equity capital is a "cost" under the Medicare Act.[37]

In support of their position, the plaintiffs note that 42 C.F.R. § 405.402(c) refers to "*costs* such as depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary providers), and other costs. . . ." (Emphasis added.) (They also note that section 405.402(f) provides that "a *return on equity capital* of proprietary facilities is an allowable *cost* in profit-making organizations." (Emphasis added.) Moreover, they also note that, for example, we said in *Homan & Crimen, Inc. v. Harris*, *supra*, at 1205, the Secretary's regulations "allow reimbursement of indirect costs required for patient care, such as depreciation on buildings and equipment, interest incurred on loans, and a *return on equity capital*." (Emphasis

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[37]The exact facts are as follows: HCA's net equity in aircraft was $480,000, of which $135,833 was attributable to current hospital operations, $305,459 was attributable to construction activities, and $38,708 was attributable to potential acquisitions which did not materialize. For simplicity, we have assumed that the aircraft was not used in connection with acquisition activities. Less than 10% of the use of HCA's aircraft was attributable to acquisition activities, and, as the plaintiffs note, "whether a return on equity is allowable to the extent that the aircraft was used in acquisition activities is dependent on the Court's resolution of the acquisition costs issue. . . .". Brief of Appellants at 53 n. 1. Since we have already decided that unconsummated acquisition costs are not reimbursable, *see* section III.C., *supra*, the plaintiffs' would not be allowed any return on equity here even if we were to accept the plaintiffs contention that return on equity is a cost.

added.) But while the plaintiffs cite several instances where both the Medicare regulations and judicial decisions do refer to a return on equity as a "cost," we believe they fail to take into account the legislative history of the Medicare reimbursement scheme and the weight of recent court decisions specifically focusing on this question.

Nowhere in the Medicare regulations is the word "cost" defined. It is used interchangeably with the words "allowance" and "expense" to mean something which is paid under the Medicare statute. Because corporate providers are paid a return on equity capital, the regulations and the courts often refer to this return as a "cost," probably because a return on equity capital is included in the provider's program reimbursement. However, a return on equity is a profit, not a cost, and it has its own independent basis in the Medicare Act. While reimbursable expenses paid by Medicare all fall under the "reasonable costs" provision, 42 U.S.C. § 1395x(v)(1)(A), a return on equity capital is provided for under section 1395x(v)(1)(B). Moreover, recent judicial decisions have carefully examined the legislative history of the return on equity capital provision and have demonstrated persuasively that a return on equity is not a "reasonable cost" as contemplated by the Medicare Act. *See St. Francis Hospital Center v. Heckler*, 714 F.2d 872 (7th Cir.1983); *Hospital Authority of Floyd County, Georgia v. Heckler*, 707 F.2d 456 (11th Cir.1983); *Saline Community Hospital Association v. Schweiker*, 554 F.Supp. 1133 (E.D.Mich. 1983). We believe these decisions to be sound and do not believe that reiterating the courts' analyses is necessary. Thus, because a return on equity in aircraft used for construction is not a "cost," such as depreciation of the aircraft,

it cannot be added to the "historical cost" of the facilities being constructed.[38] Thus, we affirm the district court's judgment on this issue.

V. CONCLUSION.

The plaintiffs have advanced many compelling arguments in support of their position on all four issues. Were we making the agency decision or devising Medicare regulations we might well adopt the outcome they urge upon us. We must be mindful, however, that the standard of our review requires that we uphold the Secretary's decision if it is reasonably consistent with the statute and is not arbitrary or capricious. We are unconvinced that the Secretary's determination is unreasonable or irrational. Thus, we affirm the district court's judgment against the plaintiffs, but reverse the district court's judgment against the Secretary. The plaintiffs shall bear the costs of this appeal.

AFFIRMED IN PART and REVERSED IN PART.

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[38]The other arguments plaintiffs offer in support of their position all presume that return on aircraft equity is a "cost;" *see* Brief of Appellants at 58-66. Since we find this presumption to be false, we do not address these remaining contentions.

APPENDIX B.

Memorandum Opinion and Order.

In the United States District Court for the Western District of Texas.

Sun Towers, Inc., Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-116.

Chippenham Hospital, Inc. and Johnston-Willis Hospital, Inc., Plaintiffs, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-255.

Lewis-Gale Hospital, Inc., Montgomery County Hospital, Inc., and Pulaski Community Hospital, Inc., Plaintiffs, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-260.

Raleigh General Hospital, a West Virginia Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-263.

McMinnville Hospital, Inc., an Oregon Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-266.

Athens Community Hospital, Inc. and Parkridge Hospital, Inc., Plaintiffs, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-267.

Redmond Park Hospital, Inc., a Georgia Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-268.

River Park Hospital, Inc., Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-270.

Humboldt Cedar Crest Hospital, Inc., Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and

Human Services, Defendant. EP-80-CA-272.

Hospital Corporation of America, Hospital Corporation of Smith and Overton Counties, and De Kalb General Hospital, Inc., Plaintiffs, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-274.

Broadway Hospital, Inc., a California Corporation; Ross General Hospital, a California Corporation; Sebastopol Hospital Corp., a California Corporation; and Ukiah Hospital Corporation, a California Corporation, Plaintiffs, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-278.

Hospital Corporation of America, a Tennessee Corporation; Trinity Hospital, Inc., a Tennessee Corporation; and Donelson Hospital, Inc., a Tennessee Corporation, Plaintiffs, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-279.

West Paces Ferry Hospital, Inc., a Georgia Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-280.

Doctors Hospital of Mobile, Inc., an Alabama Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-281.

Selma Medical Center Hospital, Inc., an Alabama Corporation, Plaintiff, v. Richard S. Schweiker, Department of Health and Human Services, Defendant. EP-80-CA-282.

University Hospital, Inc., a Delaware Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-285.

HCA-Arlington, Inc., A Texas Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-286.

Greenview Hospital, Inc., a Kentucky Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-287.

Community Hospital, Inc., a Kentucky Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-288.

Hospital Corporation of America, a Tennessee Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-289.

Malone-Hogan Hospital, Inc., a Texas Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-290.

Circle Terrace Hospital Corporation, a Virginia Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-291.

Diagnostic Center Hospital Corporation of Texas, a Delaware Corporation; and Pasadena Bayshore Hospital, Inc., a Texas Corporation, Plaintiffs, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-292.

Rio Hondo Memorial Hospital, a California Corporation; and Los Robles Regional Medical Center, a California Corporation, Plaintiffs, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-296.

De Tar Hospital, Inc., a Texas Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-299.

Fort Worth Medical Plaza, Inc., Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-311.

North Florida Regional Hospital, Inc., a Florida Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-315.

Marion Community Hospital, Inc., a Florida Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-316.

Lakeland Manor, Inc., a Delaware Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-326.

Hartselle Medical Center, Inc., an Alabama Corporation; and Crestwood Hospital and Nursing Home, Inc., an Alabama Corporation, Plaintiffs, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-80-CA-331.

Hospital Development Service Corporation, a Florida Corporation, Plaintiff, v. Richard S. Schweiker, Secretary, Department of Health and Human Services, Defendant. EP-81-CA-20.

Filed: July 30, 1982.

MEMORANDUM OPINION AND ORDER

In these consolidated cases, Hospital Corporation of America and a number of its hospital subsidiaries, including Sun Towers of El Paso, seek judicial review of an adverse decision of the Secretary of Health and Human Services pursuant to Section 1878(f)(1) of the Social Security Act, 42 U.S.C. § 1395oo(f)(1). Plaintiffs contend that (1) the Secretary's decision is procedurally invalid, and (2) it is arbitrary, capricious and not supported by substantial evidence. Both Plaintiffs and Defendant have moved for summary judgment.

The Health Insurance for the Aged Act (the "Medicare Act") was enacted in 1965 as Title XVIII of the Social

Security Act, 42 U.S.C. § 1395 et seq. Part A of the Act, 42 U.S.C. §§ 1395c - 1395i, deals primarily with hospital services. Participating hospitals, like the Plaintiffs in this case, are known as "providers of services," and are entitled to reimbursement for their reasonable costs incurred, both direct and indirect. 42 U.S.C. §§ 1395x(u), 1395x(v)(1)(A). Claims for costs by providers are periodically audited by fiscal intermediaries to insure that proper payments are being made. 42 U.S.C. § 1395h. A provider dissatisfied with an audit adjustment may appeal the intermediary's determination to the Provider Reimbursement Review Board. 42 U.S.C. § 1395oo(a). A decision of this Board concerning a cost report is a final administrative decision unless the Secretary of Health and Human Services (who apparently acts through a delegate, the Deputy Administrator of the Health Care Financing Administration) reverses, affirms or modifies the decision within 60 days. 42 U.S.C. § 1395oo(f)(1). If a provider is dissatisfied with a decision of the Board or of the Secretary, it may obtain judicial review in the United States District Court. 42 U.S.C. § 1395oo(f)(1).

In their cost report for 1973, the Plaintiffs claimed reimbursement for four categories of costs which are at issue in this case: (1) acquisition costs; (2) good will; (3) stock maintenance costs, and (4) return on aircraft equity. These costs were disallowed by the fiscal intermediaries and Plaintiffs appealed to Provider Reimbursement Review Board. The Board issued a decision on January 2, 1980, reversing the fiscal intermediaries and allowing the costs. The Plaintiffs received notice of the Board's decision on January 7, 1980. On March 6, 1980, 59 days after Plaintiffs' receipt of notice, the Secretary (acting by and through the Deputy Administrator) reversed the Board's decision on all four of these issues. Plaintiffs timely filed their complaints seeking judicial review of the Secretary's decision.

A. *Procedural Challenges.*

Plaintiffs first launch a two-pronged attack upon the timeliness of the Secretary's decision. *First*, they argue that the 60-day time limit within which the Secretary was required to act began to run on January 2, 1980, so that even a decision rendered on March 6, 1980 would have been too late. *Second*, they contend that the Deputy Administrator actually signed and entered his decision on March 10 or 11, and "backdated" it to March 6, 1980.

Plaintiffs' contention that the Secretary's time limit runs from January 2, 1980, is based upon their interpretation of the language of Section 1395oo(f)(1), which provides:

> "A decision of the Board shall be final unless the Secretary, on his own motion, *and within 60 days after the provider of services is notified of the Board's decision*, reverses, affirms or modifies the Board's decision." (emphasis added).

Plaintiffs say this language means the 60-day period begins to run on the date notice is *sent* to the provider; Defendant says it begins when notice is *received* by the provider. The Defendant's interpretation is clearly correct. In the first place, the language itself is relatively clear and unambiguous. It tortures the English language to contend that a party "is notified" of something the date the notice is mailed, rather than when he receives it. Second, the legislative history of the original enactment of § 1395oo(f)(1) in 1972 and of its amendment in 1974 supports the Secretary's view.[1] Third, the only Court of Appeals to consider the meaning of the phrase "is notified" in § 1395oo(f)(1) has interpreted it to mean that a provider "is notified" when he receives notice.

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[1]See the discussion of legislative history in Defendant Schweiker's Memorandum in Opposition to Plaintiff's Motion for Summary Judgment, pp. 10-13.

Hospital San Jorge v. Secretary of Health, Education & Welfare, 616 F.2d 580, 585 n. 6 (1st Cir. 1980).[2] Neither the Plaintiffs' arguments to the contrary, nor the unreported district court decision upon which they rely,[3] are persuasive. Neither is their contention that Defendant is collaterally estopped from arguing a position in conflict with the *McCoy* decision. It is true that federal courts have the discretion to allow "offensive" use of collateral estoppel in a proper case. *Parklane Hosiery Co. v. Shore*, 439 U.S. 322 (1979). It would be inappropriate to exercise that discretion in favor of estoppel where, as here, a legal issue with important public policy implications is involved. *Western Oil & Gas v. United States E.P.A.*, 633 F.2d 803, 809 (9th Cir. 1980); *Advanced Health Systems, Inc. v. Schweiker*, 510 F.Supp. 965, 969 (D.Colo. 1981). Federal agencies may litigate in many districts similar or identical legal questions which arise out of different fact situations without the application of collateral estoppel. *Western Oil & Gas v. United States E.P.A., supra* at 808.

The second prong of Plaintiff's attack on timeliness, to be successful, would require the Court to hold either that (1) the Deputy Administrator's decision, although dated March 6, 1980, was actually signed and entered later, or (2) regardless of the date of signature, the date his decision was *mailed* (March 11, 1980) should be considered its effective date.

In making their claim that the Deputy Administrator "backdated" his decision, Plaintiffs recognize that they

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[2]Although the First Circuit was dealing specifically with the other 60-day time limit in § 1395oo(f)(1), i.e., that within which a provider may seek judicial review, the language construed was identical to that at issue here.

[3]*McCoy d/b/a Twinbrook Convalescent Center v. Califano*, No. C77-0389-L(A)(W.D. Ky. 1980).

have the burden of overcoming the presumption of regularity that attaches to official acts of administrators. As the Supreme Court stated in *United States v. Chemical Foundation, Inc.*, 272 U.S. 1, 14-15 (1926):

> "The presumption of regularity supports the official acts of public officers, and, in the absence of clear evidence to the contrary, courts presume that they have properly discharged their official duties."

The Plaintiffs attempt to overcome the presumption of regularity in this case by asserting that (1) the same Deputy Administrator did backdate a decision in a 1979 case styled *Humana, Inc. v. Harris*, Nos. 78-0584 and 78-0175 (D.D.C. 1979); (2) although dated March 6, the decision was not mailed to the parties until March 11; (3) information obtained through discovery indicated the Deputy Administrator did not receive a draft decision from his Attorney-Advisor until March 6, 1980, so that he could not have made his review and entered his decision the same day. In contrast to the general rule of "no discovery" in a suit for judicial review of an administrative agency's decision, Plaintiffs were allowed to engage in limited discovery in this case.[4] Even armed with the fruits of that discovery, Plaintiffs have fallen far short of the "clear evidence" needed to discharge their burden of proving backdating in the instant case. The affidavits on file indicate that changes in the agency's procedure were made in the wake of the embarrassing *Humana* incident in 1979, and that it became the practice of the Deputy Administrator to date the decision in his own handwriting at the time he signed it,[5] and also to sign and date a "control sheet" which accompanied the file. The five-

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[4]See Order Regarding Discovery filed herein on May 19, 1981.

[5]Previously decisions had been dated with a date stamp by some other employee.

day delay between March 6 and March 11 (two days of which were Saturday and Sunday) is plausibly explained by the fact that the Health Care Financing Administration had two offices, one in Washington and one in Baltimore, and that the decision was signed in Washington by the Deputy Administrator but mailed from Baltimore after the file was hand carried back there. In short, the record not only fails to establish that backdating occurred, but fails to raise a genuine issue of material fact in that regard.

The Plaintiffs' alternative argument is that in view of the risk that backdating can occur, but the difficulty in proving it, the courts should adopt a "prophylactic rule" that a decision is not a decision until it is "made public" by the act of mailing it to the parties. If such a rule were applied in the instant case, the effective date would be March 11, 1980, some 64 days after Plaintiffs were notified of the Board's ruling, and the decision would be untimely. Plaintiffs have failed to establish a basis for such a novel rule. There was no extreme or inordinate delay between signing and mailing in the instant case, and Plaintiffs have not even alleged that they were prejudiced by the slight delay that did occur. Furthermore, if Plaintiffs' proposed rule were adopted, and if day 60 fell, for example, on a Friday, an official working late on that day could render a timely and correct decision, yet have it declared a nullity because mailing took place the following Monday. The record in this case does not justify the adoption of the extraordinary rule advocated by Plaintiffs.

The final procedural attack on the validity of the Secretary's ruling is the argument that the Secretary's delegate, the Deputy Administrator, did not actually review the record before rendering his decision. There is no requirement, however, that the administrative official rendering a decision read everything in a massive record word for word. *Morgan*

v. United States, 298 U.S. 468, 481 (1936); *National Nutritional Food Ass'n v. Food and Drug Administration*, 491 F.2d 1141 (2nd Cir. 1974), *cert. denied* 419 U.S. 874 (1974); *Braniff Airways, Inc. v. C.A.B.*, 379 F.2d 453 (D.C. Cir. 1967). The Deputy Administrator's decision in the instant case recites that he has considered the decision of the Board, the record before the Board, and comments received after the Board's decision. This recital is not overcome by Plaintiffs' speculation that he did not consider these items. *Braniff Airways, Inc. v. C.A.B., supra* at 462.

Having found no merit in Plaintiffs' procedural challenges to the Secretary's decision, the Court now turns to the substantive issues presented.

B. *Substantive Challenges.*

Plaintiffs claim that the Secretary's decision disallowing reimbursement of good will, stock maintenance costs, unconsummated acquisition costs, and aircraft equity is arbitrary and capricious and not supported by substantial evidence. Each of these items will be treated separately.

1. *Good Will.* During the years 1968 and 1969, Plaintiff Hospital Corporation of America acquired a number of individual hospitals; some by merger, some by purchase of 100% of the stock of an existing hospital corporation. The nine hospital corporations which were acquired by 100% stock purchase were not dissolved, but apparently continue their separate corporate existences to this day. The consideration paid[6] for each of these existing hospitals exceeded the net book value in each case, and Hospital Corporation allocated this excess to "good will." The good will was treated as part of equity capital related to *all* HCA's ac-

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[6]Seven of the nine corporations were acquired through stock swaps; the stock of the other two was purchased for cash and notes.

quisitions, by whatever means acquired, and that total amount was used in computing HCA's claim for Medicare reimbursement. The Secretary allowed reimbursement for good will with respect to hospitals acquired through statutory merger, but disallowed it for those nine acquired by means of 100% stock purchases.

The basic concept embodied in the Medicare Act is that payment is made to "providers of services," 42 U.S.C. § 1395x(u), for ". . . the cost actually incurred . . . in the efficient delivery of needed health services," 42 U.S.C. § 1395x(v)(1)(A). In the case of a proprietary hospital, a reasonable return on equity capital is such an allowable cost. 42 C.F.R. 405.429(a)(1). When a holding company like HCA acquires the stock in an existing hospital corporation, however, and the latter continues to exist as a separate corporation, two questions are presented: (1) who is the "provider of services," and (2) what costs are incurred in connection with the "delivery of . . . health services"? Both questions have been resolved against the Plaintiff by the Fifth Circuit in *Homan & Crimen, Inc. v. Harris*, 626 F.2d 1201 (5th Cir. 1980), *cert. denied* 450 U.S. 975 (1981). In that case, a holding company called Medenco, Inc. purchased 100% of the stock of Homan & Crimen, Inc., a corporation doing business as Southwestern General Hospital in El Paso, Texas. Homan & Crimen continued as a separate corporation. The money paid by Medenco for Homan & Crimen stock exceeded the net book value of the hospital by $830,000. In its Medicare cost reports, the hospital began to claim this additional sum of $830,000 as a step-up in the cost basis of its assets, and the Secretary disallowed the claim.[7] The Fifth Circuit held that Homan

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[7] The term "good will" was not used to describe the $830,000 excess of purchase price over book value in *Homan & Crimen, supra*. However, a comparison of the facts shows that the item called "good will" by HCA is exactly the same, whatever the term used to describe it.

& Crimen, Inc., the acquired corporation, was still the "provider" for Medicare purposes, and that equity capital upon which payment from Medicare could be based was *only* that related to patient care. *Homan & Crimen, Inc. v. Harris, supra* at 1209-10. The acquiring corporation, Medenco, was not entitled to a return on the purchase price of the Homan & Crimen stock. *Homan & Crimen, Inc. v. Harris, supra* at 1210.

Plaintiff argues that the Fifth Circuit decision in Homan & Crimen rests upon regulations not in existence at the time of its own acquisitions in 1968-9 (the Homan & Crimen purchase was effective January 1, 1972). It points to a section in the Provider Reimbursement Manual which states that

> "Goodwill purchased in an acquisition prior to August 1970 of an existing organization is includable in the provider's equity capital. The amount of goodwill is determined in accordance with generally accepted accounting principles." PRM § 1214.

Even if this rule is given effect, however, it does not answer the question, "who is the 'provider' "? The Homan & Crimen case does. Furthermore, the Fifth Circuit did not base its decision on any rule promulgated by an adminstrative agency, but on the Medicare statute itself and the recognized principles of corporate law. In short, a recent decision of of the Fifth Circuit is directly in point and is controlling. The Secretary acted properly in disallowing good will, and his decision in this respect must be affirmed.

2. *Stock Maintenance Costs*. The costs in dispute here are those incurred in connection with such standard corporate activities as preparation and distribution of annual reports to shareholders; holding meetings of shareholders; proxy costs and stock transfer and registration fees; legal and accounting fees incurred in S.E.C. filings, and insti-

tutional public relations. The Secretary disallowed these costs, based upon his conclusion that they were not costs necessary for the efficient delivery of health services, 42 U.S.C. § 1395x(v)(1)(A), and upon two sections of his own Provider Reimbursement Manual, §§ 2134.9 and 2150.2B, which do not allow reimbursement for these costs. The Court finds the decision to disallow these costs to be arbitrary and capricious, and contrary to law.

Most, if not all, the corporate activities which give rise to the costs in question here are mandated by state or federal law.[8] Such laws almost universally require public corporations to hold annual meetings of shareholders, make reports to shareholders, provide procedures for stock transfer, file reports with the Securities and Exchange Commission and state agencies, etc. If Hospital Corporation of America did not comply with these laws, it could not engage in its business, which is providing hospital care to patients. These costs are thus an indirect cost of furnishing health services. 42 U.S.C. § 1395x(v)(1)(A)(i); *AMI-Chanco, Inc. v. United States*, 576 F.2d 320, 323 (Ct.Cl. 1978). The statement in the Provider Reimbursement Manual that such costs are "primarily for the benefit of stockholders or other investors,"[9] whether true or not, is irrelevant. Whoever Congress or the state legislatures meant to protect when they enacted laws requiring these corporate activities, the fact remains that a hospital corporation, like any other corporation, must comply with them if it wants to stay in business. *AMI-Chanco, Inc. v. United States, supra*, and its business is delivering health services to patients.

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[8] An exception would seem to be the cost of institutional public relations concerning stock and financial matters.

[9] PRM § 2134.9.

Furthermore, the disallowance of these costs flies in the face of a Medicare regulation which prohibits inequitable treatment of profit making and not-for-profit hospitals. 42 C.F.R. § 405.402(b)(5). Nonprofit organizations are reimbursed for the costs they incur in connection with annual meetings and reports; costs indistinguishable from those disallowed in this case. *AMI-Chanco, Inc. v. United States, supra* at 324. The Secretary's action also contradicts two other principles embodied in the Medicare Act: that costs of treating Medicare patients not be shifted to non-Medicare patients, 42 U.S.C. § 1395x(v)(1)(A), *AMI-Chanco, Inc. v. United States, supra* at 323, and that publicly owned, profit-making providers should be allowed to attract and keep equity capital to maintain and expand their services. 20 C.F.R. 405.429(b)(1); *AMI-Chanco, Inc. v. United States, supra* at 324.

Finally, as Plaintiffs correctly point out, classifying these particular expenses under the heading of "stock maintenance costs" is, in itself, artificial and arbitrary. Under generally accepted accounting principles, they are simply part of the corporation's general and administrative costs. Simons & Karrenbrock, *Intermediate Accounting* (4th Ed), p. 34. The accounting profession does not recognize a separate category of "stock maintenance costs." Neither do other federal agencies, which consider these costs simply part of the ordinary and necessary expenses of corporate business. *AMI-Chanco, Inc. v. United States, supra* at 325.

In disallowing these costs, which totaled $185,021.00,[10] the Secretary acted arbitrarily and capriciously, and contrary to the Medicare Act and the regulations thereunder. In this regard, his decision must be reversed.

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[10]Memorandum in Support of Plaintiffs' Motion for Summary Judgment, p. 58.

3. *Unconsummated Acquisition Costs.* In 1973, HCA considered thirteen hospitals for acquisitions. Eight of them were in fact acquired. The Secretary disallowed reimbursement for costs incurred by HCA in investigating and evaluating those hospitals which were *not* acquired.

As discussed earlier herein, Medicare normally reimburses only those costs incurred by a "provider" of health services. However, if a cost incurred by an organization related to the provider by common control or ownership results in the furnishing of a service, facility, or supplies to the provider, that cost is reimbursable by Medicare. 42 C.F.R. § 405.427. The Secretary was correct in finding that no provider received any services, facilities or supplies as a result of costs incurred by HCA in investigating possible acquisitions that didn't pan out, nor was health care delivered to anyone as a result of these costs. Therefore, under the law and regulations, no reimbursement was due. The Secretary's decision must be affirmed.

4. *Aircraft Equity.* In its 1973 Home Office Cost Statement, Hospital Corporation of America included the equity in three airplanes it owned and used for various business purposes. The fiscal intermediaries found a portion of the total amount claimed was allocable to construction in process, another portion to investigation of potential acquisitions that never materialized, and still another to patient care. The intermediaries allowed the return on equity allocable to patient care, and that decision is not disputed. The disallowance of the portion applicable to unconsummated acquisitions was also correct. See discussion in Part B1 of this opinion, *supra*. The remaining question is HCA's entitlement to return on equity for that portion of aircraft use related to construction in process.

This issue has been greatly confused by loose and inaccurate use of terms. The fiscal intermediaries did not dis-

allow the eventual inclusion of aircraft *equity* in the historical cost of completed new hospitals; they allowed it.[11]However, they disallowed a *return on equity* for aircraft use as a current cost item for the cost year in question.[12]The decision of the PRRB, which Plaintiffs purport to agree with, is not to the contrary. The Board apparently agreed with the fiscal intermediaries that equity in aircraft which was allocable to construction in process could be added to the historical cost of the completed hospital facility, but that a return on equity computation for the current year was not proper. The confusion begins with the wording of the Board's decision concerning this issue, which, quoted in its entirety, is as follows:

> "The Intermediaries are reversed. The equity in H.C.A.'s aircraft which is related to construction in process may be capitalized."[13]

If the Board agreed with the basic position of the fiscal intermediaries on this point, why did it make the statement, "The Intermediaries are reversed"? Possibly because HCA presented the issue as being whether or not a *return on equity* could be capitalized.[14]

When the matter reached him for decision, the Secretary did his best to eliminate the confusion. With respect to the aircraft equity issue, his decision states in part:

> "The Board's holding on this issue is not entirely clear. . . . The Board's decision on this issue implies

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[11]The Intermediary's Position Paper to the PRRB stated that "the program portion of the cost and equity of the capitalized aircraft costs would be recovered, through depreciation charges and allowances for equity, after the constructed asset is placed into use for patient care services." Administrative Record, p. 1853.

[12]Administrative Record, p. 1854.

[13]Administrative Record, p. 182.

[14]Administrative Record, p. 4162, 4180-4191. The issue is being phrased in similar form by Plaintiffs in this Court. Memorandum in Support of Plaintiffs' Motion for Summary Judgment, p. 82.

> that aircraft equity related to construction in process should be included in the historical cost of the completed assets and reimbursed accordingly. This, however, is not the issue being appealed.
>
> "The parties agreed that the costs associated with the aircraft use for construction should be capitalized, but the Provider contended further that *a return* on the net aircraft equity should also be either currently reimbursed or capitalized."[15]

The Secretary went on to hold that costs incurred in constructing new hospitals, including aircraft costs (both out-of-pocket and depreciation), should be capitalized and included in the historical cost of the completed hospital. These costs would then be included in net equity for computing a return on equity in the future, when the new hospital began to provide actual services to Medicare patients. The Secretary held, however, that neither the net equity in the airplanes, nor a return on that equity, could be capitalized under Medicare law, or under generally accepted accounting principles.

The foregoing illustrates the difficulty in determining to what extent the Board disagreed with the intermediaries, or the Secretary disagreed with the Board. The Court has no difficulty in deciding, however, that the Secretary's decision was correct. "Return on equity" is payable only on equity capital that is used in providing health services to patients. 42 C.F.R. 405.429(a)(1). While it is under construction, a hospital is not providing patient care services. Furthermore, return on equity is not a cost incurred that falls within the definition of historical cost in 42 C.F.R. 405.415(b)(1), and it would not be proper to capitalize it. The Board did not hold that return on equity should be capitalized, and Plain-

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[15]Administrative Record, p. 23.

tiffs have said they agree with the Board. With respect to "equity," it also is not a cost incurred within the definition of 42 C.F.R. 405.415(b)(1), and is not properly capitalized. In this respect, the Secretary did modify the Board's decision, and his decision should be affirmed.

C. *Conclusion.*

With respect to the so-called "stock maintenance costs," Plaintiffs have discharged their burden of showing that the Secretary's decision disallowing such costs was arbitrary and capricious, and contrary to law. The decision of the Secretary in this respect must be reversed. In all other respects, the Defendant's motion for summary judgment should be granted and the decision of the Secretary dated March 6, 1980, should be affirmed.

It is therefore ORDERED that with respect to the disallowance of "stock maintenance costs" in the approximate amount of $185,021.00, the Plaintiffs' motion for summary judgment be, and it is hereby, GRANTED, and the decision of the Secretary be, and it is hereby, REVERSED.

It is further ORDERED that with respect to the other issues presented, the Defendant's motion for summary judgment be, and it is hereby, GRANTED, and the decision of the Secretary be, and it is hereby, AFFIRMED.

SIGNED AND ENTERED this 30th day of July, 1982.

/s/ Harry Lee Hudspeth
HARRY LEE HUDSPETH
UNITED STATES DISTRICT JUDGE

APPENDIX C.

Decision.

Health Care Financing Administration.

Decision of the Administrator.

In the Case of: Hospital Corporation of America Group Appeal No. 1. Provider. vs. Blue Cross Association. Mutual of Omaha Insurance Company. Aetna Life and Casualty. Intermediary.

Claim for: Provider Cost Reimbursement Determination of Reasonable Costs for Cost Reporting Period(s) Ending Various 1973 and 1974.

Review of: PRRB Decision No. 80-D2.

Dated: January 2. 1980.

This group appeal is before the Deputy Administrator. Health Care Financing Administration. for review on own motion of the decision entered on January 3. 1980. by the Provider Reimbursement Review Board. The review is undertaken pursuant to Section 1878(f)(1) of the Social Security Act. as amended [42 USC 1395oo].

Comments requesting that the Administrator review and reverse the Board's decision on Issue Nos. 1. 4. 5. and 6 were received on January 15 from a division of the Bureau of Program Policy. and on January 17 from the Blue Cross Association. one of the three Intermediaries in this case. Copies of these were furnished to the Providers. On January 31. the parties were notified of the intention to review the Board's decision on these four issues. and of their right to submit comments during the course of this review under the Interim Procedures governing this review. On February 21. comments were received from the Providers regarding procedural aspects of the Administrator's review. No comments concerning the merits of this case were received from the

Providers. All comments have been made a part of the administrative record. Accordingly, the case is now before the Deputy Administrator for final administrative decision.

ISSUES AS STATED BY THE BOARD

"1. To what extent are costs incurred by HCA relating to the acquisition of hospitals allowable?

"2. Are certain contributions made to charitable organizations (i.e., United Givers Fund, Muscular Dystrophy Association, Middle Tennessee Heart Association, Cerebral Palsy Association, Nashville Symphony, Opportunity Industrialization Center, Cheekwood, American Cancer Society, City of Hope, Miscellaneous) by HCA allowable costs?

"3. Are premiums paid for key-man life insurance an allowable cost?

"4. Are stock maintenance costs incurred by HCA allowable?

"5. Is the equity in HCA's aircraft used in connection with facilities under construction and in connection with abandoned plans to acquire facilities reimbursable under Medicare?

"6. Is purchased good will in the acquisition of hospitals includable in the computation of equity capital?"

PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

"Issue No. 1 — Acquisition Costs (Majority Opinion)

"The Intermediaries are reversed. The costs incurred for those acquisitions that were not consummated is allowable.

"Issue No. 2 — Charitable Contributions

"The Intermediaries are affirmed. The charitable contributions of HCA are not allowable costs.

"*Issue No. 3 — Key-Man Life Insurance*

"The Intermediaries are affirmed. Key-man life insurance is not related to patient care.

"*Issue No. 4 — Stock Maintenance Costs*

"The Intermediaries are reversed. The stock maintenance costs of HCA are proper and necessary costs.

"*Issue No. 5 — Aircraft Equity*

"The Intermediaries are reversed. The equity in HCA's aircraft which is related to construction in process may be capitalized.

"*Issue No. 6 — Goodwill (Majority Opinion)*

"The Intermediaries are reversed. The acquisitions by HCA were purchases. Accordingly, the excess purchase price is considered goodwill."

DISSENTING OPINIONS

Issue No. 1

The then Board Chairman dissented on this issue. He wrote that where a cost relates to an acquisition of a facility not currently owned, or perhaps not even currently participating in the Medicare program, the policy is not to recognize those costs. It is deemed to be too remote. Abandoned acquisition costs do not meet the requirement of 42 CFR 405.451(c)(3) that the determination of reasonable cost of services must be based on cost related to the care of Medicare beneficiaries.

Issue No. 6

One Board member dissented on this issue. He wrote that Health Care Financing Administration Ruling 78-33 is relevant in this case and controls the decision. Goodwill is not a reasonable cost and does not relate directly to delivery of health care.

SUMMARY OF INTERMEDIARY'S COMMENTS

The Blue Cross Association, one of the three Intermediaries in this case, requested that the Administrator review and reverse the Board's decision on Issue Nos. 1, 4, 5, and 6. The Intermediary wrote that it assumes the Administrator will review and reverse the Board's decision on Issue No. 4, concerning stock maintenance costs, and Issue No. 6, concerning the inclusion of goodwill in computing equity capital since those issues have been the subject of numerous reversals.

On Issue No. 1, the Intermediary commented that abandoned acquisition costs are not now nor have they ever been reimbursable under the Medicare Program. These costs are not related to patient care under 42 CFR 405.451. The Intermediary further stated that one of the first requirements that must be met before any cost can be claimed under the program is that those costs must be claimed by a "provider of services" as that term is defined in Section 1861 of the Social Security Act. Since the costs were incurred in searching for new facilities no facility existed, and therefore, no provider of services existed. The Intermediary also commented that the Board's decision could lead to the reimbursement of costs incurred by those who explored but abandoned investment opportunities in the hospital industry even though such an individual may not own any other interests in the industry.

On Issue No. 5, the Intermediary commented that under 42 CFR 405.429 a return on equity is permitted only on assets used in providing patient care. The portion of the Providers' aircraft costs in dispute related to construction and acquisition activities. There is no basis for capitalizing and deferring to the future a return on equity capital. The Intermediary also stated that the Board's decision is inconsistent with 42 CFR 405.415. If the Board's decision on

this issue is not reversed, it could lead to the inclusion of all kinds of assets not related to patient care in the computation of the return on equity capital.

SUMMARY OF COMMENTS FROM THE DIVISION OF INSTITUTIONAL SERVICES REIMBURSEMENT

The Division requested that the Administrator reverse the Board's decision on Issue Nos. 1, 4, 5, and 6. Concerning Issue Nos. 4 and 6, stock maintenance costs and goodwill, the Division commented that it had previously recommended reversals on those issues.

Concerning Issue No. 1, the Division commented that the Board's decision to allow costs associated with abandoned plans to buy existing facilities violates 42 CFR 405.451 and Section 2154 of the Provider Reimbursement Manual (HIM-15-1). Costs incurred in investigating potential acquisitions which are never consummated are neither provider costs nor are they incurred in providing services to Medicare beneficiaries.

On Issue No. 5, the Division stated that the decision of the Board should be reversed because there is no return on equity allowable under the Medicare program for assets not used in providing patient care. Assets related to construction-in-progress are not being used to provide patient care. The Division also stated that the Board's decision violated 42 CFR 405.429(a)(1). This regulation is reinforced by Section 1218.4 of the Provider Reimbursement Manual (HIM 15-1) which specifically sttates that assets and liabilities related to construction-in-progress are excluded from equity capital. Therefore, the Division commented, a return on equity capital for the cost of the aircraft relative to construction-in-progress is not allowable cost under the Medicare program.

SUMMARY OF PROVIDERS' COMMENTS

The Providers submitted various comments concerning the procedures used in conducting final administrative review.

EVIDENCE CONSIDERED

General

All the evidence which was before the Provider Reimbursement Review Board has been considered, including the sworn testimony of the witnesses at the hearing before the Board, and the position papers and the exhibits submitted by the parties. All comments received after entry of the Board's decision have been made a part of the record.

The statement of facts set forth by the Board in its decision is incorporated by reference, as are the parties' Joint Stipulation on Issues and Facts. The following is added concerning the general background of the case and Issue Nos. 1, 4, 5, 6.

This group appeal involves 47 Medicare certified hospitals which are part of a chain organization, Hospital Corporation of America. HCA is a for-profit Tennessee corporation which presently owns, operates, or manages over 130 acute care hospitals with a total of over 20,000 beds. During the period involved in this appeal, HCA owned or managed providers with more than 8,700 beds. The Providers in this appeal are located primarily in the southern and western United States.

One of the founders of HCA indicated at the hearing that HCA formed and established its home office in 1968, in Nashville, Tennessee, by acquiring its "flagship", Parkview Hospital, the name of which was subsequently changed to Hospital Corporation of America (Transcript of Oral Hearing (Tr. 25, July 9, 1979)). This witness stated that the idea of forming such a company came from observing

what happened in the motel industry when Holiday Inn brought economies of scale and sharing of services together (Tr. 24, July 9, 1979).

* * *

Issue No. 4

In 1973 HCA incurred $187,521 in costs referred to in the record as stock maintenance costs. These costs were allocated to the 47 Providers in this group appeal. The costs include: (1) costs relating to annual stockholders' reports; (2) stock transfer and registration fees; (3) costs relating to stockholders' meetings; (4) accounting and other costs relating to Securities and Exchange Commission filings; and (5) institutional public relations costs relating to stock and financial matters (IPP, p. 38); (PPP No. IV, p. 3); (Joint Stipulation on Issues and Facts, p. 8).

The Professor of Economics testified for the Providers that stock maintenance costs are not incurred for the benefit of investors, but are incurred in order for the company to maintain an equity position. An equity position represents savings to the Medicare program (Tr. 406, 7/11/79); (PPP No. IV, Exh. Vol. II, Exh. R). This witness further testified that without them, the company could not raise capital through equity and would indirectly have to pay higher interest rates on its debt (Tr. 406).

* * *

DISCUSSION AND EVALUATION

The entire record which was before the Provider Reimbursement Review Board has been examined, including all position papers and exhibits submitted by the parties, the stipulations agreed to by the parties, the transcript of the oral hearings before the Board, and the post-hearing brief and submission. The Board's decision has been carefully

reviewed and the comments received after the Board issued its decision have been noted by the Deputy Administrator.

* * *

Issue No. 4

This issue concerns whether the costs identified and classified in the record as the home office corporations stock maintenance costs which were allocated to the Providers in this appeal may be allowable for Medicare reimbursement purposes. The Board held that the stock maintenance costs are proper and necessary costs. The Board held that the provisions of Section 2134.9 of the Provider Reimbursement Manual (HIM-15) lack regulatory authority, are discriminatory in nature, and are contrary to a Court of Claims opinion in a different case in which certiorari to the Supreme Court was not sought.

As brought out in t discussion on Issue No. 1, the costs of a home office corpo tion are not directly reimbursable under the Medicare law and regulations. However, subject to several limitations, such costs may be allocated to the Medicare providers in the chain and reimbursed under the related organizations principle.

Under Medicare Regulations, 42 CFR 405.427, the home office corporation and the Providers are related organizations. 42 CFR 405.427(b)(1) defines "related to provider . . ." as "the provider to a significant extent is associated or affiliated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies." By virtue of ownership of 100 percent of the stock of the Providers, HCA "has the power directly or indirectly, significantly to influence or direct the actions or policies . . ." of the Providers, and accordingly, meets the definition of control under 42 CFR 405.427(b)(3).

Under 42 CFR 405.427(a), "costs applicable to services, facilities, and supplies . . ." furnished to a provider by an organization to which it is related by control may, subject to several limitations, be considered allowable costs of the providers. Therefore, to the extent HCA furnishes services, facilities, and supplies to its related Providers, the reasonable costs of such items may be allowable to the Providers.

The governing law, Section 1861 of the Social Security Act, as amended [42 USC 1395x] lists and defines many specific items, such as surgical dressings, splints, braces, etc., which are to be considered reimbursable "services, facilities, or supplies" for Medicare purposes. There is, however, no mention of stock maintenance costs as being covered "services, facilities, or supplies." A review of the legislative history of the Act reveals no indication that the Congress considered stock maintenance costs as a service, facility, or supply.[1]

Under the Medicare Act, a 16-member body was created in 1965 for the purpose of providing advice in the formulation of Medicare regulations.[2] This group was named the Health Insurance Benefits Advisory Council. The Council in its discussion of the principles of reimbursement, upon which the Reimbursement Regulations are based, did not mention stock maintenance costs when discussing services, facilities, and supplies.[3]

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[1]S. REP. NO. 404, 89th Cong., 1st Sess. 36 (1965), at 27-28, 31, 33, 48, 185; H.R. REP. NO. 213, 89th Cong. 1st Sess. 32 (1965), at 24-25, 28-29, 41, 167.

[2]Social Security Act §1867, 79 Stat. 286 (1965), *as amended* 42 U.S.C. §1395 dd. (1970).

[3]Health Insurance Benefits Advisory Council: *Minutes*, Chronological Summary of 3d meeting at 35, (Dec. 17-19, 1965); Health Insurance Benefits Advisory Council: *Minutes*, Chronological Summary of 5th meeting at 29 (Jan. 28-30, 1966).

This review of the Act and its legislative history, and of the Regulation and background, reveals no basis for any holding that stock maintenance costs are a service, facility, or supply. Since only the costs applicable to services, and supplies furnished to the Providers by a related organization, in this case the home office corporation, are includable in the allowable costs of the Providers under 42 CFR 405.427(a), it follows that stock maintenance costs may not be allowed under this Regulation.

Stock maintenance costs are costs of the home office corporation which are not subject to allocation to the Providers for Medicare reimbursement purposes. The Providers received no services, facilities, or supplies as a result of HCA incurring stock maintenance costs to maintain its own corporate status and equity capital. The relationship between HCA and the Providers does not bestow a right to shift costs applicable only to the home office corporation to the Providers with the resultant effect of obtaining Medicare reimbursement for such costs.

Even if the stock maintenance costs could be considered a service, facility, or supply, these costs cannot be considered reasonable costs related to patient care. Reasonable cost for program reimbursement purposes is defined in Section 1861(v)(1)(A) of Title XVIII of the Social Security Act, as amended, [42 USC 1395x]. This Section requires that "reasonable cost . . . be the cost actually incurred, excluding therefrom any part of incurred costs found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. . . ." Further, the "regulations shall (i) take into account both direct and indirect costs of providers of services . . . ." It is clear from this reading that the regulations issued by HEW were meant to further

define reasonable costs by specifically stating the methods and items involved in the reasonable cost determination. However, the Act mandates that costs unnecessary to rendering patient care services are not reasonable costs.

A review of the Regulations, 42 CFR 405.451(a), shows that payments to providers "must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries." Reasonable cost includes "necessary and proper costs incurred in rendering the services . . . ." Under 42 CFR 405.451(b)(1), reasonable cost "must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." 42 CFR 405.451(b)(2) amplifies that "necessary and proper costs" are only those costs which are "appropriate and helpful in developing and maintaining the operation of patient care facilities and activities." Also, they are costs which are "common and accepted occurrences in the field of the *provider's* activity." (Emphasis Supplied) 42 CFR 405.451(c)(3) requires, in pertinent part, that "where the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, . . . such amounts will not be allowable." Moreover, the cost of "items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services . . ." are not allowable.

To the extent that HCA incurred patient care costs directly for the Providers in this appeal, such costs are included in the Providers' allowable costs under the Regulations, and as explained in § 2150.2A. of the Provider Reimbursement Manual (HIM-15). Such costs incurred by HCA are considered by the program to be home office costs. Where home office costs are not "otherwise allowable costs when incurred directly by the provider . . .," these costs may not

"be allowable as home office costs to be allocated to providers." This Manual section is a proper interpretation of the Act and 42 CFR 405.451 in that a home office cost must be related to patient care services furnished by providers in order to be allowable under the program.

Concerning stock maintenance costs, there is no reference to these specific costs in either the Act or the Regulations. However, two sections in the Manual provide an interpretation of the regulations concerning whether stock maintenance costs are related to patient care. 2150.2B.1 of the Manual describes the home office costs which are not considered allowable. This section refers to 2134.9 in disallowing stock maintenance costs. 2134.9 of the Manual explains that stock maintenance costs "are not related to patient care . . . ." Also, such costs are "incurred primarily for the benefit of stockholders or other investors. . . ."

The Manual shows that 2150, dealing with home office costs, was first placed in the Manual by Revision No. 68 dated January 1973. Under § 2150.2B., in that Revision, "Costs relating to corporate stock maintenance . . ." were not considered allowable costs. The transmittal sheet to Revision No. 68 explained that § 2150 was added to the Manual to clarify "the treatment of home office costs for Medicare reimbursement purposes. . . ." Accordingly, from this examination of the applicable Manual Sections, it is clear that the provisions of § 2134.9 which are now reflected in the Manual apply to the Providers in this appeal.

The Board's conclusion that § 2134.9 of the Manual lacks regulatory authority. However, that section does restate and clarify existing Regulations which do not allow stock maintenance costs under the program. These costs are disallowed because they are not considered to be related to patient care. Rather, the costs are incurred for the benefit of the corporation's stockholders. Since these costs are "specifically

not reimbursable under the program . . .'' as not relating to patient care, 42 CFR 405.451(c)(3) requires that ''such amounts will not be allowable.'' The Manual instructions are clearly interpretive of the Regulation in disallowing stock maintenance costs as not related to patient care.

The Joint Stipulation on Issues and Facts submitted by the parties in this case breaks down some of the various stock maintenance costs. Such costs include those associated with stockholders' meetings, legal and accounting fees related to SEC filing requirements, annual stockholder reports, stock transfer and registration fees, and public relations costs relating to stock and financial matters. The fact that all of these costs may be necessary to the home office corporation to maintain its corporate existence does not alter the fact that these costs are not considered related to patient care under the Regulations and the interpretive Manual sections cited.

Obviously, patient care services may be rendered without incurring stock maintenance costs. It is the construction of the organizational entity providing the services, not the patient care services, which gives rise to stock maintenance costs. It is recognized that some stock maintenance costs are necessary for a publicly held corporation to maintain its corporate status; however, these costs are not ''related to the care of beneficiaries . . .'' as required by 42 CFR 405.451(a) for Medicare reimbursement.

Stock maintenance costs are not ''appropriate and helpful in developing and maintaining the operation of patient care facilities and activities,'' or ''common and accepted occurrences in the field of the provider's activity,'' as required by 42 CFR 405.451(b)(2) in order to be viewed as necessary costs related to patient care. If these costs are related to patient care, the costs would be incurred by hospitals operated by nonprofit institutions and those providers which

do not the have shareholders. However, this is not the situation. Patient care services may be rendered by hospitals which are not publicly held corporations without incurring stock maintenance costs. Consequently, patient care services do not give rise to stock maintenance costs. Thus, stock maintenance costs are not necessary for patient care.

The Board's finding that the disallowance of stock maintenance costs discriminates between investor-owned and nonprofit providers has been noted. However, the disallowance of costs not related to patient care is not discriminatory. The fact that stock maintenance costs are unique to publicly held for-profit corporations does not alter the determination that the costs are not related to patient care. The costs are not disallowed solely because they are not incurred by all providers.

The Act and 42 CFR 405.451 impose a strict definition on reasonable cost. In order for a cost to be reimbursable under the program, it must, among other limitations, be related to patient care. No matter how necessary stock maintenance costs may be to the HCA home office corporation in maintaining its corporate existence, these costs cannot be construed as relating to the patient care services of the Providers since patient care services do not generate such costs. Further, costs that are not necessary for the efficient delivery of needed health services are not reimbursable under Section 1861(v)(1)(A) of the Act, [42 USC 1395x].

The Program allows a return on equity capital invested and used in the provision of patient care by proprietary providers. The amount allowable is determined by applying to the providers' equity capital a percentage equal to one and one-half times the average rate of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each month in the providers' reporting periods.

The relationship between stock maintenance costs and the return on equity capital allowed under the program requires analysis of Section 1861(v)(1)(B) of the Act, as amended, [42 USC 1395x]. Here, a specific item relating to the owner's investment in facilities rendering extended care services is included in reasonable cost. This Section requires that the "regulations in the case of extended care services furnished by proprietary facilities shall include provisions for specific recognition of a reasonable return on equity capital. . . . in lieu of other allowances to the extent that they reflect similar items." The following sentence states that the return on equity capital is "for determining the reasonable cost of any services furnished . . . ." The return on equity capital, therefore, is viewed as a part of reasonable cost, in lieu of other allowances to the extent they reflect similar items.

It is interesting to note that Section 1861(v)(1)(B) of the Act refers only to extended care services, not to hospital services. The Regulation, 42 CFR 405.429, however, permits a return on equity capital for hospital services as well. A review of the history of Section 1861(v)(1)(B) shows that it was enacted nearly a year after the enactment of the Medicare program, including Section 1861(v)(1)(A). In the Conference Committee's Report which accompanied H.R. 6958, subsequently codified as Section 1861(v)(1)(B), similar principles were expected to be applied to proprietary hospitals: "The conferees expect that the Secretary of Health, Education, and Welfare will apply similar or comparable principles in determining reasonable costs for reimbursement of proprietary hospitals for services furnished by them."[4]

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[4]H.R. REP. NO. 2317, 89th. Cong., 2d. Sess. (1966), p. 31, U.S. Code Cong. & Admin. News 1966, p. 3676, 3692, and 3693).

Congress intended that similar or comparable principles to those in Section 1861(v)(1)(B) of the Act be applied in the Regulations to proprietary hospitals. The Regulation permitting an allowance for return on equity capital for hospitals is 42 CFR 405.429. Subpart (a) is specific in permitting a return on equity capital used in rendering patient care services "as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers." The purpose of allowing a return on equity capital is stated in 42 CFR 405.429(b)(1) "to avoid withdrawal of capital and to attract additional capital needed for expansion." Thus, under this Regulation, the return on equity capital recognizes the investment for patient care and that an allowance for this investment is a necessary cost under the program.

Clearly, then, 42 CFR 405.429, like Section 1861(v)(1)(B) of the Act, names a specific item for inclusion in reasonable costs. In addition to reimbursing providers the actual costs of rendering extended care services under Section 1861(v)(1)(A), Congress also intended that a return on investment in patient care activities be paid proprietary hospitals. Section 1861(v)(1)(B) states that this return is "in lieu of other allowances to the extent that they reflect similar items." While the legislative history of Section 1861(v)(1)(B) contains no specific reference to this statement, it appears evident that Congress intended to allow the return on investment in patient care facilities rather than allowing specific items of cost relating to the investment.

Because 42 CFR 405.429, as it relates to hospitals, adopted "similar or comparable principles" to those contained in Section 1861(v)(1)(B), the basic principle that the allowance is "in lieu of other allowances to the extent that they reflect similar items" was extended to hospitals in the Regulation. The only allowance for investment in patient care which is

permitted by this Regulation is the return on equity capital.

The stock maintenance costs in this case have the objective of maintaining equity capital for the home office corporation. 42 CFR 405.429 achieves this objective for the Providers by allowing a return on equity capital. To permit the Board's decision to stand and allow stock maintenance costs of HCA would circumvent this Regulation. The Regulation clearly intends to allow only the return for the Providers. This would be true even in situations where providers directly incur stock maintenance costs. Surely, it would be a misinterpretation of the Regulation in this case to allow stock maintenance costs of the home office corporation plus a return on equity capital for the Providers.

* * *

FINDINGS OF FACT

General

1. The Deputy Administrator adopts the Findings made by the Provider Reimbursement Review Board on Issue Nos. 2 and 3, concerning reimbursement of charitable contributions and premiums for key-man life insurance, respectively.

2. The amount of Medicare reimbursement in dispute exceeds $50,000 for the cost reporting periods at issue.

3. Except for Issue No. 6, 47 Medicare Providers of the Hospital Corporation of America (HCA) are involved in this group appeal.

4. HCA is a publicly held corporation which owns, manages, and operates hospitals for profit.

5. The home office of HCA is located in Nashville, Tennessee.

* * *

Issue No. 4

13. Medicare reimbursement for the stock maintenance costs incurred by the home office corporation, Health Corporation of America are in dispute.

14. The home office corporation allocated its stock maintenance costs to the Providers in this appeal.

15. The 47 Providers did not receive any health care services, facilities, or supplies for the stock maintenance costs incurred by the home office corporation.

16. The 47 Providers claimed the allocated stock maintenance costs for reimbursement under the Medicare program.

17. The stock maintenance costs were incurred by the home office corporation to maintain its equity and corporate status.

18. The Intermediaries disallowed Medicare reimbursement for the home office corporation's stock maintenance costs allocated to the Providers.

* * *

CONCLUSIONS OF LAW

The Deputy Administrator adopts the Conclusions made by the Provider Reimbursement Review Board on Issue Nos. 2 and 3 concerning reimbursement of charitable contributions and premiums paid for key-man life insurance, respectively.

* * *

7. The home office corporation and the Providers are organizations related by control within the meaning of 42 CFR 405.427(a) and (b)(3).

8. The home office corporation's stock maintenance costs allocated to the Providers did not constitute services, facilities, and supplies furnished by a related organization

under 42 CFR 405.427(a) or Section 1861 of the Social Security Act, as amended, [42 USC 1395x].

9. Not representing services, facilities, and supplies furnished by a related organization, the home office corporation's stock maintenance costs allocated to the Providers are not includable in the allowable costs of the Providers under 42 CFR 405.427(a).

10. The home office corporation's stock maintenance costs allocated to the Providers are not necessary for the Providers' efficient delivery of services covered by Medicare under Section 1861(v)(1)(A) of the Social Security Act, as amended, [42 USC 1395x].

11. The home office corporation's stock maintenance costs allocated to the Providers do not represent reasonable costs of services covered by Medicare and related to the care of beneficiaries as required by Section 1861(v)(1)(A) of the Social Security Act, as amended [42 USC 1395x], and 42 CFR 405.451(a).

12. Medicare funds may not be used to reimburse the Providers for the stock maintenance costs under Sections 1814(b) and 1861(v) of the Social Security Act, as amended [42 USC 1395f and x] and 42 CFR 405.451(a).

13. The home office corporation's stock maintenance costs claimed by the Providers are not necessary and proper costs appropriate and helpful in patient care activities, neither are they common and accepted occurrences in the field of the Providers' activities as required by 42 CFR 405.451(b)(2).

14. The claimed stock maintenance costs of the home office corporation are specifically excluded from program reimbursement and in excess of costs necessary for needed health services under 42 CFR 405.451(c)(3) as interpreted by §2134.9 and §2150.2B.1 of the Provider Reimbursement

Manual (HIM-15).

15. The return on the Providers' equity capital invested and used for patient care is the only cost permitted for investment under 42 CFR 405.429(a).

16. Being costs related to the home office corporation's investment, the stock maintenance costs allocated to the Providers are not reasonable costs related to patient care under Section 1861(v)(1)(B) of the Social Security Act, as amended, [42 USC 1395x].

* * *

DECISION

* * *

Issue No. 4

The decision of the Board on Issue No. 4 is reversed. The stock maintenance costs incurred by the home office corporation and allocated to the Providers are not allowable.

* * *

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

Date: March 6, 1980

/s/ Earl M. Collier, Jr.
Earl M. Collier, Jr.
Deputy Administrator,
Health Care Financing Administration

APPENDIX D.

Decision.

Provider Reimbursement Review Board Hearing Decision 80-D2.

Provider — Hospital Corporation of America Group Appeal No. 1, Home Office Audit December 31, 1973 (Appendix A) vs. Intermediary — Blue Cross Association, Mutual of Omaha Insurance Company, Aetna Life and Casualty.

Date of Hearing — July 9, 10, 11, 12 & 13, 1979.

Cost Reporting Period Ending See Appendix A.

Case No. 77-202G.

ISSUES:

1. To what extent are costs incurred by HCA relating to the acquisition of hospitals allowable?
2. Are certain contributions made to charitable organizations (i.e., United Givers Fund, Muscular Dystrophy Association, Middle Tennessee Heart Association, Cerebral Palsy Association, Nashville Symphony, Opportunity Industrialization Center, Cheekwood, American Cancer Society, City of Hope, Miscellaneous) by HCA allowable costs?
3. Are premiums paid for key-man life insurance an allowable cost?
4. Are stock maintenance costs incurred by HCA allowable?
5. Is the equity in HCA's aircraft used in connection with facilities under construction and in connection with abandoned plans to acquire facilities reimbursable under Medicare?
6. Is purchased good will in the acquisition of hospitals includable in the computation of equity capital?

STATEMENT OF FACTS:

The Hospital Corporation of America (HCA) is a publicly held corporation which owns, manages, and operates hospitals for profit. As a general rule, HCA's facilities are general short-term hospitals. As of December 31, 1973, HCA managed and/or owned approximately 54 facilities. This appeal is being brought to the Board by HCA on behalf of its Medicare Providers as a result of an audit of its December 31, 1973, home office costs. The total amount in dispute is approximately $1,023,000 (expense issues $133,600, return on equity capital $889,400).

Notices of Program Reimbursement were issued to the Providers as shown on Appendix A. Pursuant to 42 CFR § 405.1841, the Providers filed timely requests for a Group Appeal before the Provider Reimbursement Review Board. A hearing was held July 9 through July 13, 1979.

* * *

Issue No. 4 — Stock Maintenance Costs

During the period involved in this appeal HCA had various types of securities outstanding. These securities included various long-term notes, secured and unsecured, approximately 9,000,000 shares of issued and outstanding common stock, stock options granted under two qualified stock option plans and issued under a non-qualified stock option plan (together totalling approximately 328,000 shares under option) and warrants for the purchase of shares issued to two insurance companies, which warrants authorized the purchase of an additional 500,900 shares. Pursuant to an audit of HCA's Home Office costs, the Intermediaries categorized the following costs as stock maintenance costs:

Annual Report to Stockholders	$ 25.351
Stock Transfer and Registration Fees	91.480
Stockholders' Meetings	3.772
Legal and Accounting Fees Related to Securities and Exchange Commission Filings and Stockholders' Meetings	37.173
Institutional Public Relations Relating to Stock and Financial Matters	27.245
	$185.021

These items were removed from the Providers' allowable costs. The Providers have taken exception to this determination.

* * *

Issue No. 4 — Stock Maintenance Costs

Providers

The Medicare Act and regulations define costs to include "indirect costs" which are incurred to provide services to patients. Corporate stock maintenance costs are indirect costs of providing patient care for 12 reasons: (1) they are ordinary and necessary business expenses, and a separate classification of such costs based on the assertion they are not related to patient care is arbitrary; (2) program regulations make no distinction between corporations and forms of other entities operating a hospital and corporate maintenance costs should, therefore, not be treated differently than costs of other forms of entities; in fact, the program requires corporate providers to comply with laws relating to corporate status as a condition of participating in the program; (3) all other costs of raising capital are allowed, and it is arbitrary to disallow the costs in issue here which are incurred in

order to raise capital; (4) because they are related to procuring equity capital, they produce lower borrowing costs; (5) they are consistent with program regulations which encourage hospitals to raise capital through equity investment; (6) they are reimbursed to individual investor-owned providers and non-profit providers, and it is discriminatory to disallow them to publicly held investor-owned providers; (7) they are reimbursed by private third party payment organizations and by other government reimbursement programs; (8) disallowance of such costs requires hospitals or non-program patients to bear such costs in violation of law; (9) they were incurred as part of borrowing requirements and costs of borrowing are allowable; (10) they were incurred as part of costs of employee compensation under stock option plans, and employee fringe benefits are allowable; (11) rules disallowing stock maintenance costs were invalidly adopted in that there was no Administrative Procedure Act compliance; and (12) disallowance of such costs is inconsistent with regulations which support their reimbursement.

A corporate provider of services is expressly recognized as being acceptable to the program. [42 CFR §§ 405.603(b) and 405.429(a)(2)] Payment for indirect costs of providers of services would necessarily include business expenses relating to the corporate entity. Disallowance of stock maintenance costs is, therefore, inconsistent with the provisions recognizing a corporate provider of services. The Regulations contain no prohibition against reimbursing costs relating to the formation of a corporation.

Program Instructions in HIM-15-1 provide that corporate organization costs are to be reimbursed to providers. These costs include organization costs such as legal fees and accounting fees, together with the costs of directors' fees, incorporation fees, and the organization meetings of direc-

tors and stockholders, and other costs required to create the corporate entity. The allowance for such costs is set forth in HIM-15-1, § 2134.1A.

Costs relating to the creation of the corporation entity are thus considered necessary and proper in providing patient care. Nevertheless, the Intermediaries assert that while the costs of creating the corporation are allowed, costs of stockholders' meetings and reports and costs of filing required by the Securities and Exchange Commission to legally maintain the entity are not. The continued operation of a corporate investor-owned provider would be legally impossible without incurring most, if not all, of the costs in question here. HCA, a Tennessee corporation, is required by Tennessee law to hold meetings of stockholders for the purpose of electing directors. (Sections 48-701 and 48-804 Tenn. Code Ann) Since an annual meeting is required for the stockholders to elect directors who control the corporations' policies and select its management, the stockholders' meeting is fundamental to a corporation's operation. Moreover, reports to stockholders informing them of a corporation's revenues and expenses, assets and liabilities, description of operations, information on management and the other myriad of details of a modern business corporation, is absolutely essential to an intelligent decision to carry out the stockholders' function of electing directors.

As noted, the costs of organizing the corporation are allowed under Section 2134.1A of the Manual, but similar costs incurred annually by law are disallowed. The distinction has never been explained. HCA stockholders also select, annually, the company's auditors and one of the stated purposes of the 1973 stockholders' meeting was to approve the selection of auditors. The practice of stockholders selecting the company's auditors is a practice endorsed by the SEC and is considered to be an important function of the stock-

holders with respect to corporate affairs. Tennessee law also provides that non-profit corporations have meetings of members. (Section 48-701 Tenn. Code Ann) Such meetings, including reports to members of non-profit corporations, are allowed by Medicare. Neither the Regulations nor Manual provisions disallow non-profit corporation costs of such meetings or reports.

Moreover, Leo Roads, second Vice President for Mutual of Omaha, a party in this case, recognized that similar costs at issue are paid to non-profit providers.

"BY MR. KLEIN:

Q. In the Mutual of Omaha capacity as the fiscal Intermediary has it, does it review the records of non-profit corporate Providers?

A. Yes, it does.

Q. And do those corporate Providers in some instances incur some costs similar to those identified here in corporate stock maintenance costs?

A. Yes, they do.

Q. Among those costs are the costs of an annual members meeting and annual report of the Provider?

A. Yes.

Q. Let's take them one at a time. First with respect to the annual members meeting. Are those costs allowed by the Program?

A. Yes, they are.

Q. Has Mutual ever disallowed such costs since the inception of the program?

A. Not on non-profit type corporations, no.

Q. Is there any difference in your mind Mr. Roads between a members meeting of non-profit corporation and a stockholders meeting of investor-owned companies?

A. From a personal standpoint no. I cannot find any.

Q. The purpose seems to be the same?

A. Ye.. yes it does.

Q. Now with respect to the reports if I may just show you examples of two such reports identified as report of University Hospital of Cleveland, their annual '78 report. Buffalo General Hospital annual '77 report. These are two reports of non-profit companies identified as Exhibits CC and CC1. My question Mr. Roads is whether those reports are typical of the annual reports issued by non-profit institutions?

A. They would appear to be typical of the non-profit hospitals which we serve, yes.

Q. The same glossy paper?

A. Yes.

Q. The same fancy pictures?

A. The same types of pictures.

Q. Similar cost and expense for introducing the report?

A. Right. The outlines of their services. Pictures of individuals in the hospital. Usually a picture of the hospital center itself, medical center.

Q. The medical center. Some general financial information. Perhaps not as detailed of that provided by the investor-owned but financial information is contained in them?

A. Right.

Q. Any difference in your mind between the reports which I have just shown you and those types of reports produced by investor-owned facilities?

A. I wouldn't see a lot of difference in them, no. (Transcript Page 441, line 10)

Mr. Road's position is also shared by Peter Cotter, formerly of Blue Cross of Southern California, in an affidavit in evidence in this hearing. In addition, testimony of Walter McConnel, another Blue Cross of Southern California em-

ployee, testified in Case No. 76-142G (American Medical International, Inc.) that it was the practice of Blue Cross of Southern California to allow the costs in dispute in this issue to non-profit providers.

Thus, while costs of stockholders' meetings and reports to owners of investor-owned facilities are deemed not related to patient care, similar costs when incurred by non-profit hospitals are paid by the the Medicare program. Not only is there no logic to the distinction between investor-owned and non-profit corporations, but Regulations expressly prohibit discrimination in cost reimbursement principles applied to non-profit organizations and profitmaking organizations. [42 CFR § 405.402(b)(5)]

The Provider's find additional support in the allowance of stock maintenance costs from the decision of *AMI-Chanco, Inc. v. The United States* which was decided by the U.S. Court of Claims. The Court of Claims found that the decision to deny stock maintenance costs by the fiscal Intermediary of the Provider was:

> ". . . inconsistent with the statutory purpose and other regulations of the same agency that we cannot uphold that decision. Although 'stock maintenance expenses' are a special classification coined by H.E.W., we find that they are actually general and administrative expenses, which are indirectly related to and necessarily incurred in providing the Medicare services involved in this case."

Further, the Provider Reimbursement Review Board in previous cases have held that stock maintenance costs are allowable. (PRRB Decision Nos. 77-D89 and 77-D61.) Both decisions were reversed by the Administrator of the Health Care Financing Administration and subsequently appealed to the U.S. District Court. In *Decision No. 77-61* the Board stated:

"The Board believes that 'Stock Maintenance Costs' are indirectly related to patient care. It is not reasonable to claim that all 'Stock Maintenance Costs' are unrelated to patient care. It is inconsistent to allow the costs of borrowing funds and not to allow the related and necessary stock maintenance costs. 'Stock Maintenance Costs' have many things in common with the costs of acquisition of borrowed funds. the Program allows the expenses on borrowed capital and the Board fails to see a distinction between borrowed capital and stock maintenance. The cost of procuring equity funds does not differ in substance from the cost of obtaining any other type of capital.

The Board does not agree with the Intermediary that 'Stock Maintenance Costs' become allowable costs through the return on equity capital. The return on equity was not set up for this purpose. Such costs are indirectly related to patient care and, therefore, should be reimbursed on a cost basis. Furthermore, no evidence was presented by the Intermediary to establish that recognition had ever been given in the rate of return to reflect the inclusion of 'Stock Maintenance Costs.' "

The Court of Claims, in *Chanco*, further recognized that it was contradictory to encourage the attraction of investment capital but disallow the costs of doing so on the ground that the costs are not related to patient care.

"By directing that corporate providers shall receive a reasonable return on equity capital, Congress has declared that it considers a reasonable return on investment to be one of the costs of patient care which is reimbursable under the Act. Surely, if Congress meant to bolster the effectiveness of the Medicare program by offering the incentive of a return on equity to investors of capital, it also intended to provide reimbursement for stock maintenance costs, which by their very definition are essential elements of the process of at-

> tracting the equity capital necessary to provide patient care services. In fact, it is a contradictory policy which encourages the attraction of investment capital but disallows the costs of doing so, on the grounds that the latter costs are not related to patient care."

The Providers also note that in a memorandum from the Office of the General Counsel, dated December 20, 1978, to the Administrator of the Health Care Financing Administration the following discussion took place with respect to *Chanco*:

> "The Under Secretary wanted us to seek Supreme Court review of this decision. We were convinced that such an effort would be futile in the absence of a clear regulation denying these costs."

Finally, the Intermediaries argue that stock maintenance costs are somehow covered by Medicare's return on equity. The purpose of establishing a return on equity as understood by Dr. Michael Intriligator, an expert witness, is to "prevent withdrawal of capital in the industry and also to attract additional capital for the industry." (Transcript 374, line 10). Dr. Intriligator concluded that if stock maintenance costs are paid from the rate of return, the rate of return no longer represents the market rate. The Providers further argue that the rate of return of 150 percent of the average earnings on the purchases of the Federal Insurance Trust Fund is hardly adequate to cover the costs which are in dispute in this case in light of the findings and conclusions of a study conducted by the ICF Incorporated (Provider Position Paper No. III, Exhibit W.)

> "3. Under the Medicare ROE formula, return on equity payments should have been based upon a 3.7 Hospital Trust Fund multiplier rather than the current 1.5 multiplier . . .

4. *Medicare disallowances of certain unavoidable hospital expenses or investments can produce effective Medicare ROEs which are below the appropriate nominal rates identified above*. Consequently, higher Hospital Trust Fund multipliers might be needed to ensure that effective ROEs are commensurate with the ROEs in similar risk industries. Such unavoidable costs disallowed by Medicare include income taxes, routine SEC registration costs, and other stock maintenance costs."

In addition, an HEW economist has acknowledged that the rate of return allowed by the regulation is "substantially below the average rates of return in (a) all manufacturing, (b) utilities regulated by the U. S. Power Commission and (c) the hospital management industry itself." Accordingly, the HEW economist concluded:

> "Thus, in my opinion, the appropriate rate of return on equity in investor-owned hospitals should be roughly equivalent to the rate of return allowed investors in other similar assets. Such a rate could be achieved either by (1) allowing taxes to be considered a cost of business, (2) by increasing the multiple applied to the FHITF interest rate, or (3) by selecting another interest rate as the base, such as the interest rate on AAA mature corporated bonds."
>
> (Note to Peter Fox from Robert Woodward, HEW Economist, Provider's Position Paper No. III, Exhibit Y)

Moreover, the Court of Claims in *Chanco* found:

> "The government also contends, apparently as an alternative argument, that the statutory provision made by Congress for a return on equity to corporate providers was intended to include reimbursement for stock maintenance costs within the specified percentage rate

for a return on equity. In section 1861 (v)(1)(B) of the Social Security Act, Congress set the rate of return at not more than 1.5 times the average rate for interest paid on certain obligations issued to the Federal Hospital Insurance Trust Fund.

We find that there is no merit in this belated contention, which was not raised in the administrative proceedings. The government cites no legislative history, documentation, or authority of any kind in support of this proposition. Its argument is based almost solely on its unsupported interpretation of the provision in 42 U.S.C. § 1395x(v)(1)(B) (Supp. V 1975) that a reasonable return on equity is to be paid 'In lieu of other allowances to the extent that they reflect similar items.' The government says that stock maintenance costs are such 'other allowances.' In the absence of any legislative history to the contrary, we find that a plain reading of the statute indicates that the payment of the return on equity capital is in lieu of other 'similar' payments for the use of capital. Reimbursements for stock maintenance costs are not similar to payments for use of capital."

Thus, the Providers find no basis for the disallowance of stock maintenance costs.

Intermediaries

It is the contention of the Intermediaries that stock maintenance costs are not related to patient care inasmuch as they are incurred primarily for the benefit of stockholders. For costs to be considered related to patient care they must be appropriate and helpful in developing and maintaining the operation of patient care facilities and activities as in the context of PRM HIM-15 Section 2102.2. The stock maintenance costs do not represent actual patient care services, supplies or facilities furnished by the parent corporation to its subsidiary providers. Such stock maintenance

costs are not related to actual patient care and are not necessary to the rendition of patient care services. Rather, such stock maintenance costs are associated with HCA's proprietary corporate status and with the investment of the Corporation's stockholders. Since the stock maintenance costs are for the benefit of shareholders, such costs cannot be allocated to HCA's subsidiaries and included in allowable costs of the subsidiaries.

It is important to distinguish between costs which are necessary for the maintenance of the proprietary corporate structure and costs which are necessary for providing medical services. For a corporation to exist, stock maintenance costs are not a necessary expense. It is only HCA's decision to exist as a publicly held proprietary corporation which gives rise to these expenses. However, medical services can be rendered to beneficiaries without the proprietary form of corporate structure. This distinction evidences that the purpose of stock maintenance costs are directed at benefiting the shareholders' investment. The remoteness of stock maintenance costs to the rendering of patient care services prohibits recognition of these expenses as allowable cost.

The principle under which stock maintenance costs are nonallowable is found in HIM-15-1, Section 2134.9, as adapted as a *clarification* in Revision No. 75 in August of 1973.

> "2134.9 *Stockholder Servicing Costs.*—The following types of costs relevant to the proprietary and equity interests of the stockholders, but not related to patient care, are excluded from allowable costs: costs incurred primarily for the benefit of stockholders or other investors, including, but not limited to, the costs of stockholders' annual reports and newsletters, annual meetings, mailing of proxies, stock transfer agent fees, stock exchange registration fees, stockbroker and investment

analysis, and accounting and legal fees for consolidating statements for SEC purposes."

In addition, the Administrator's reversal of Provider Reimbursement Review Board *Decision No. 77-D61*, as it deals with Stock maintenance, supports the treatment of these costs as nonallowable. In this decision the Administrator states:

"Stock Maintenance costs are costs of the parent company which are not subject to allocation to the providers for Medicare reimbursement purposes. The providers received no services, facilities, or supplies as a result of the Parent Company incurring Stock Maintenance Costs to maintain its own corporate status and equity capital. The relationship between the Parent Company and the providers does not bestow a right to shift cost applicable only to the Parent Company to providers with the resulting effect of obtaining Medicare reimbursement for such cost.

Even if the Stock Maintenance could be considered a service, facility, or supply, these costs cannot be considered resonable costs related to patient care.

Patient care services may be rendered without incurring stock maintenance costs. It is the construction of the organizational entity providing the services, not the patient care services, which gives rise to stock maintenance costs.

No matter how necessary stock maintenance cost may be to the Parent Company in maintaining its corporate existence, these costs cannot be construed as relating to the patient care services of the providers since patient care services do not generate such costs."

These statements, by the Administrator and the subsequent affirmation in the case of *American Medical International, Inc. v. Secretary*, U.S., CA No. 77-1921, CD D.C. 1979, agree with the contention of the Intermediaries

that stock maintenance costs are not related to patient care under 42 U.S.C. 1395x(v)(1)(b) and Regulation 405.451.

Return on equity capital for proprietary providers is intended by statute to be in "lieu of other allowances to the extent they reflect similar items." [Title XVIII, § 1861(v)(1)(B)] Thus, it appears that the intent of Congress was to allow a return on investment in patient care facilities by proprietary providers in lieu of allowing specific items of costs of attracting and servicing investors, such as stockholder maintenance costs. Accordingly, the Intermediaries contend that their disallowance of stock maintenance costs is proper.

* * *

CONCLUSIONS AND FINDINGS:

* * *

Issue No. 4 — Stock Maintenance

The Intermediaries' adjustments are reversed. The Board finds that the provisions of § 2134.9, HIM-15-1, lacks regulatory authority and are discriminatory in nature. HCA has clearly demonstrated that costs similar to those disallowed by the Intermediaries have been consistently allowed to nonprofit corporations. More importantly, due note should be made of the decision rendered by the Court of Claims in *AMI — Chanco, Inc. v. United States*, 576 F. 2d 320, concerning HCFA's policy of not allowing Medicare reimbursement for stock holder servicing costs of proprietary hospital corporations. In *Chanco*, the Court of Claims found:

> ". . . We find that H.E.W. acted arbitrarily in adopting and enforcing the provisions in question because they are not consistent with the basic objectives of the enabling legislation, with other Medicare regulations adopted pursuant to that legislation, or with other government regulations which allow the same costs in other

contexts."

In further support of HCA's argument a Decision Memorandum dated December 20, 1978, from the Office of General Counsel, Health Care Financing and Human Development Services Division, HEW to the Administrator of HCFA, was entered into the Record. In pertinent part, the Memorandum stated:

> "The Under Secretary wanted us to seek Supreme Court review of this decision (Chanco). We were convinced that such an effort would be futile in the absence of a clear regulation denying these costs."

Accordingly, the Board finds that the evidence presented unequivocally supports the contentions of HCA.

* * *

DECISION:

Issue No. 1 — Acquisition Costs (Majority Opinion)

The Intermediaries are reversed. The costs incurred for those acquisitions that were not consummated is allowable.

Issue No. 2 — Charitable Contributions

The Intermediaries are affirmed. The charitable contributions of HCA are not allowable costs.

Issue No. 3 — Key-Man Life Insurance

The Intermediaries are affirmed. Key-man life insurance is not related to patient care.

Issue No. 4 — Stock Maintenance Costs

The Intermediaries are reversed. The stock maintenance costs of HCA are proper and necessary costs.

Issue No. 5 — Aircraft Equity

The Intermediaries are reversed. The equity in HCA's aircraft which is related to construction in process may be capitalized.

Issue No. 6 — Goodwill (Majority Opinion)

The Intermediaries are reversed. The acquisitions by HCA were purchases. Accordingly, the excess purchase price is considered goodwill.

Board Members Participating

Arthur P. Owens (Dissent on Issue No. 1)
Carolyn B. Lewis
H. Joseph Curl (Dissent on Issue 6)

FOR THE BOARD

January 2, 1980

/s/ Arthur P. Owens
Arthur P. Owens, Chairman

APPENDIX E.

United States Court of Appeals, for the Fifth Circuit.

Sun Towers, Inc., et al., Plaintiffs-Appellants-Cross-Appellees, versus Margaret M. Heckler, Secretary, Department of Health and Human Services, Defendant-Appellee-Cross-Appellant. No. 82-1481; D. C. Docket No. EP-80-CA-116, et al.

Appeals from the United States District Court for the Western District of Texas.

Before: BROWN and RANDALL, Circuit Judges, and HUNTER**, District Judge.

JUDGMENT

This cause came on to be heard on the record on appeal and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, affirmed in part and reversed in part;

IT IS FURTHER ORDERED that plaintiffs-appellants cross appellees pay to defendant-appellee-cross-appellant, the costs on appeals to be taxed by the Clerk of this Court.

February 21, 1984

Issued as Mandate: April 12, 1984

**District Judge of the Western District of Louisiana, sitting by designation.

APPENDIX F.

In the United States District Court for the Western District of Texas.

Sun Towers, Inc., Plaintiff, [et al.] v. Margaret M. Heckler, Secretary of Health and Human Services, Defendant.

EP-80-CA-116 [et al].

April 17, 1984.

JUDGMENT AFTER REMAND.

On April 12, 1984, the United States Court of Appeals for the Fifth Circuit entered its judgment affirming in part and reversing in part the judgment previously entered by this Court. In accordance with the opinion and judgment of the Fifth Circuit, the following judgment should be entered.

It is ORDERED, ADJUDGED, and DECREED that judgment be, and it is hereby, entered for the Defendant, and that the Plaintiffs take nothing by their suit.

It is further ORDERED, ADJUDGED, and DECREED that the Plaintiffs pay to the Defendant its costs on appeal in an amount to be taxed by the Clerk of the United States Court of Appeals.

SIGNED AND ENTERED this 17th day of April, 1984.

/s/ Harry Lee Hudspeth
HARRY LEE HUDSPETH
United States District Judge

APPENDIX G.

42 U.S.C. § 1395f(b) *Amount paid to provider of services*

The amount paid to any provider of services (other than a hospice program providing hospice care) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1395e and 1395ww of this title, be—

(1) except as provided in paragraph (3), the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title and as further limited by section 1395rr(b)(2)(B) of this title, or (B) the customary charges with respect to such services;

* * *

42 U.S.C. § 1395x(v) *Reasonable costs*

(1)(A) The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types of classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may

provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services,

in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed one and one-half times the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

* * *

42 U.S.C. § 1395*oo* *Provider Reimbursement Review Board*

(a) Establishment

Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) of this section and (except as provided in subsection (g)(2) of this section) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—

(1) such provider—

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under

subsection (b) or (d) of section 1395ww of this title,

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply.

(2) the amount in controversy is $10,000 or more, and

(3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i), or with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

* * *

(f) Finality of decision: judicial review; determinations of Board authority; jurisdiction; venue; interest on amount in controversy

(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance,

or modification by the Secretary is received. Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which such determination is rendered. If a provider of services may obtain a hearing under subsection (a) of this section and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). The Board shall render such determination in writing within thirty days after the Board receives the request and such accompanying documents and materials, and the determination shall be considered a final decision and not subject to review by the Secretary. If the Board fails to render such determination within such period, the provider may bring a civil action (within sixty days of the end of such period) with respect to the matter in controversy contained in such request for a hearing. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located (or, in an action brought jointly by several providers, the judicial district in which the greatest number of such providers are located) or in the District Court for the District of Columbia and shall be tried pursuant to the applicable provisions under chapter 7 of Title 5, notwithstanding any other provisions in section 405 of this title. Any appeal to the Board or action for judicial review by providers which are under common ownership or control

must be brought by such providers as a group with respect to any matter involving an issue common to such providers.

(2) Where a provider seeks judicial review pursuant to paragraph (1), the amount in controversy shall be subject to an annual interest beginning on the first day of the first month beginning after the 180-day period as determined pursuant to subsection (a)(3) of this section and equal to the rate of return on equity capital established by regulation pursuant to section 1395x(v)(1)(B) of this title and in effect at the time the civil action authorized under paragraph (1) is commenced, to be awarded by the reviewing court in favor of the prevailing party.

(3) No interest awarded pursuant to paragraph (2) shall be deemed income or cost for the purposes of determining reimbursement due providers under this chapter.

* * *

(h) Composition and compensation

The Board shall be composed of five members appointed by the Secretary without regard to the provisions of Title 5, governing appointments in the competitive services. Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant. Members of the Board shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding the rate specified (at the time the service involved is rendered by such members) for grade GS-18 in section 5332 of Title 5. The term of office shall be three years, except that the Secretary shall appoint the initial members of the Board for shorter terms to the extent necessary to permit staggered terms of office.

* * *

42 CFR § 405.402 *Cost reimbursement; general.*

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution. However, payments to providers of services for services rendered health insurance program beneficiaries are subject to the provisions of §§ 405.455 and 405.460.

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the provider that takes account of the actual use of services by the beneficiaries of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of development of recordkeeping.

(5) That the principles should result in the equitable treatment of both nonprofit organizations and profitmaking organizations.

(6) That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

(c) As formulated herein, the principles give recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital of proprietary facilities. However, costs such as depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary providers), and other costs related to certain capital expenditures are subject to the provisions of § 405.435, "Nonallowable costs related to certain capital expenditures." With respect to allowable costs some items of inclusion and exclusion are:

(1) An appropriate part of the net cost of approved educational activities will be included.

(2) Costs incurred for research purposes, over and above usual patient care, will not be included.

(3) Grants, gifts, and income from endowments will not be deducted from operating costs unless they are designated by the donor for the payment of specific operating costs.

(4) The value of services provided by nonpaid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish such services, is includable in the amount that would be paid others for similar work.

(5) Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

(6) Bad debts growing out of the failure of a beneficiary to pay the deductible, or the coinsurance, will be reimbursed (after bona fide efforts at collection).

(7) Charity and courtesy allowances are not includable, although "fringe benefit" allowances for employees under a formal plan will be includable as part of their compensation.

(8) A reasonable allowance of compensation for the services of owners in profitmaking organizations will be allowed providing their services are actually performed in a necessary function.

(9) Reasonable cost of physicians' direct medical and surgical services (including supervision of interns and residents in the care of individual patients) rendered in a teaching hospital may be reimbursed as a provider cost (see § 405.465) where elected as provided for in § 405.521 of this part.

(d) In developing these principles of reimbursement for the health insurance program, all of the considerations inherent in allowances for depreciation were studied. The principles, as presented, provide options to meet varied situations. Depreciation will essentially be on an historical cost basis but since many institutions do not have adequate records of old assets, the principles provide an optional allowance in lieu of such depreciation for assets acquired

before 1966. For assets acquired after 1965, the historical cost basis must be used. All assets actually in use for production of services for title XVIII beneficiaries will be recognized even though they may have been fully or partially depreciated for other purposes. Assets financed with public funds may be depreciated. Although funding of depreciation is not required, there is an incentive for it since income from funded depreciation is not considered as an offset which must be taken to reduce the interest expense that is allowable as a program cost.

(e) [Reserved]

(f) A return on the equity capital of proprietary facilities is an allowable cost in profit-making organizations. The rate of return may not exceed one and one-half times the average long-term rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(g) The Health Care Financing Administration is authorized to issue temporary instructions modifying the provisions of this subpart to the extent it finds appropriate for cost reporting periods ending after June 30, 1973, in order to implement sections 201 (Coverage for Disability Beneficiaries Under Medicare) and 2991 (Chronic Renal Disease Considered to Constitute Disability) of Pub. L. 92-603. In so doing, rules may be developed for establishing limits on costs and services above which reimbursement shall be made only upon appropriate justification. Rules implementing these provisions of Pub. L. 92-603 apply for renal dialysis items and services furnished before August 1, 1983. Items and services furnished on or after that date are reimbursed and reported under §§ 405.439 and 405.441 respectively. For special rules concerning health maintenance organizations, (HMO's) and providers of services and other health care facilities that are owned or operated by an HMO, or related to an HMO by common ownership or control, see §§ 405.2042(b)(14) and 405.2050(c).

42 C.F.R. § 405.406 *Financial data and reports.*

(a) *General.* The principles of cost reimbursement will require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under title XVIII involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

* * *

42 C.F.R. § 405.419 *Interest expense.*

(a)(1) *Principle.* Necessary and proper interest on both current and capital indebtedness is an allowable cost. However, interest costs are not allowable if incurred as a result of—

(i) Judicial review by a Federal court (as described in § 405.454(1)),

(ii) An interest assessment on a determined overpayment (as described in § 405.376), or

(iii) Interest on funds borrowed to repay an overpayment (as described in § 405.454(1) or § 405.376).

(2) *Exception.* In those cases of administrative or judicial reversal, interest paid on funds borrowed to repay an overpayment and interest assessed on an overpayment is an allowable cost, in accordance with this section.

(b) *Definitions*—(1) *Interest.* Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a

relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long-term loans.

(2) *Necessary.* Necessary requires that the interest:

(i) Be incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments would not be considered necessary.

(ii) Be incurred on a loan made for a purpose reasonably related to patient care.

(iii) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds. Income from funded depreciation or provider's qualified pension fund is not used to reduce interest expense. Interest received as a result of judicial review by a Federal court (as described in § 405.454(1)) is not used to reduce interest expense.

(3) *Proper.* Proper requires that interest:

(i) Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

(ii) Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans from the provider's donor-restricted funds, the funded depreciation account, or provider's qualified pension fund.

(c) *Borrower-lender relationship.* (1) To be allowable, interest expense must be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the

borrower. Presence of any of these factors could affect the "bargaining" process this usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans should be made under terms and conditions that a prudent borrower would make in armslength transactions with lending institutions. The intent of this provision is to assure that loans are legitimate and needed, and that the interest rate is reasonable. Thus, interest paid by the provider to partners, stockholders, or related organizations of the provider would not be allowable. Where the owner uses his own funds in a business, it is reasonable to treat the funds as invested funds or capital, rather than borrowed funds. Therefore, where interest on loans by partners, stockholders, or related organizations is disallowed as a cost solely because of the relationship factor, the principal of such loans shall be treated as invested funds in the computation of the provider's equity capital under § 405.429.

(2) Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to providers by partners, stockholders, or related organizations made prior to July 1, 1966, is allowable as cost, provided that the terms and conditions of payment of such loans have been maintained in effect without modification subsequent to July 1, 1966. Where the general fund of a provider "borrows" from a donor-restricted fund and pays intereset to the restricted fund, this interest expense is an allowable cost. The same treatment is accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a provider operated by members of a religious order borrows from the order, interest paid to the order is an allowable cost.

(3) Where funded depreciation is used for purposes other than improvement, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will be accorded deposits in the provider's qualified pension fund where such deposits are used for other than the purpose for which the fund was established.

(d) *Loans not reasonably related to patient care.* (1) The following types of loans are not considered to be for a purpose reasonably related to patient care:

(i) For loans made to finance acquisition of a facility, that portion of the cost that exceeds:

(A) Historical cost as determined under § 405.415(b); or

(B) The cost basis determined under § 405.415(g); and

(ii) Loans made to finance capital stock acquisitions, mergers, or consolidations for which revaluation of assets is not allowed under § 405.415(1).

(2) In determining whether a loan was made for the purpose of acquiring a facility, we will apply any owner's investment or funds first to the tangible assets, then to the intangible assets other than goodwill and lastly to the goodwill. If the owner's investment or funds are not sufficient to cover the cost allowed for tangible assets, we will apply funds borrowed to finance the acquisition to the portion of the allowed cost of the tangible assets not covered by the owner's investment, then to the intangible assets other than goodwill, and lastly to the goodwill.

* * *

42 C.F.R. § 405.429 *Return on equity capital of proprietary providers.*

(a) *Principle*—(1) *Rate of return.* (i) A reasonable return on equity capital invested and used in the provision of patient care is paid as an allowance in addition to the

reasonable cost of covered services furnished to beneficiaries by proprietary providers.

(ii) Except as provided in paragraph (a)(1)(iii) of this section, the amount allowable on an annual basis is determined by applying to the provider's equity capital a percentage equal to one and one-half times the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the program.

(iii) For cost reporting periods beginning on or after April 20, 1983, the amount allowable in determining the return related to inpatient hospital services is determined using a percentage equal to the average of the rates of interest as described in paragraph (a)(1)(ii) of this section.

(2) *Proprietary providers.* For the purposes of this subpart the term "proprietary providers" is intended to distinguish providers, whether sole proprietorships, partnerships, or corporations, that are organized and operated with the expectation of earning profit for the owners, from other providers that are organized and operated on a nonprofit basis.

(b) *Application*—(1) *Computation of equity capital.* Proprietary providers generally do not receive public contributions and assistance of Federal and other governmental programs in financing capital expenditures. Proprietary institutions historically have financed capital expenditures through funds invested by owners in the expectation of earning a return. A return on investment, therefore, is needed to avoid withdrawal of capital and to attract additional capital needed for expansion. For purposes of computing the allowable return, the provider's equity capital means:

(i) The provider's investment in plant, property, and equipment related to patient care (net of depreciation) and

funds deposited by a provider who leases plant, property, or equipment related to patient care and is required by the terms of the lease to deposit such funds (net of noncurrent debt related to such investment or deposited funds), and

(ii) Net working capital maintained for necessary and proper operation of patient care activities. 1. However, debt representing loans from partners, stockholders, or related organizations on which interest payments would be allowable as costs but for the provisions of §405.419(b)(3)(ii), is not substracted in computing the amount of equity capital as defined in paragraph (b)(1)(i) of this section and this paragraph (b)(1)(ii), in order that the proceeds from such loans be treated as a part of the provider's equity capital. In computing the amount of equity capital upon which a return is allowable, investment in facilities is recognized on the basis of the historical cost, or other basis, used for depreciation and other purposes under the health insurance program.

* * *

42 C.F.R. § 405.451 *Cost related to patient care.*

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under title XVIII of the Act and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in § 405.455.

(b) *Definitions*—(1) *Reasonable Cost.* Reasonable cost of any services must be determined in accordance with reg-

ulations establishing the method or methods to be used, and the items to be included. The regulations in this subpart take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both title XVIII and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year.

(2) *Necessary and proper costs.* Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the provider's activity.

(c) *Application.* (1) It is the intent of title XVIII of the Act that payments to providers of services should be fair to the providers, to the contributors to the health-insurance trust funds, and to other patients.

(2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in title XVIII of the Act for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation where a particular institution's costs are found to be substantially out of line with other institu-

tions in the same area which are similar in size, scope of services, utilization, and other relevant factors.

(3) *The determination of reasonable cost of services* must be based on cost related to the care of beneficiaries of title XVIII of the Act. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, where the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health service), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

* * *

HIM-15 § 2134.1 *Organization Costs—General.*—Organization costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and thus affect the costs of future periods of operation.

A. *Allowable Organization Costs.*—Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of

original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to States for incorporation.

B. *Unallowable Organization Costs.*—The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate State or Federal Authorities, stamp taxes, etc.

Unless specified otherwise herein, the provisions of this section are effective for providers after June 30, 1976.

* * *

HIM-15 § 2134.9 *Stockholder Servicing Costs.*—The following types of costs relevant to the proprietary and equity interests of the stockholders, but not related to patient care, are excluded from allowable costs: costs incurred primarily for the benefit of stockholders or other investors, including, but not limited to, the costs of stockholders' annual reports and newsletters, annual meetings, mailing of proxies, stock transfer agent fees, stock exchange registration fees, stockbroker and investment analysis, and accounting and legal fees for consolidating statements for SEC purposes.

* * *

HIM-15 § 2150. HOME OFFICE COSTS—CHAIN OPERATIONS

A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A

which are engaged in other activities not directly related to health care. (See §§ 1002.2 and 1002.3 for definitions of common ownership and control.)

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicare program is that of a related organization to participating providers. Home offices usually furnish central management and administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent the home office furnishes services related to patient care to a provider, the reasonable costs of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain.

Very often the home office of a chain organization charges the providers in the chain a management fee for the services the home office furnishes. Management fees charged between related organizations are not allowable costs, except where § 1010 is applicable, and such fees must be deleted from the provider's cost report. However, where management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are includable as allowable costs of the provider. The instructions for preparation of a home office cost statement containing schedules for the determination of home office costs and equity capital, and their allocation, are set forth in § 2153.

Section 2150 is not applicable to franchise fees (see §§ 2133ff.), management fees or fees for other services paid by a provider where there is no common ownership or control between the provider and the franchisor or other service organization, or where the exception to the related organization principle applies (see § 1010).

* * *

HIM-15 § 2150.2 *Determination of Allowable Costs.*—

A. *General.*—Home office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, administrative salaries, etc.) are allowable to the extent they are reasonable (see § 2102.1). Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. For example, certain advertising costs (see § 2136.2), some franchise taxes and other similar taxes (see § 2122.4), costs of noncompetition agreements (see § 2105.1), certain life insurance premiums (see § 2130), certain membership costs (see §§ 2138.3 and 2138.4) or those costs related to nonmedical enterprises are not considered allowable home office costs. In addition, where an owner, as defined in chapter 9, received compensation for services provided by the home office, the compensation is allowable only to the extent that it is related to patient care (see § 902.2) and to the extent that it is reasonable (see § 902.3).

B. *Organization, Start-Up, and Other Corporate Costs.*—

1. *Organization Costs.*—The organization costs of a home office (*except those referred to below*) are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions in §§ 2134ff. Section 2134.1B describes costs which are not considered

allowable organization costs. In addition, reorganization costs (see § 2134.10) and stockholder servicing costs (see § 2134.9) are not allowable organization costs. These unallowable organization costs are excluded from the computation of the home office equity capital.

2. *Start-Up Costs.*—Start-up costs of a home office are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions of §§ 2132ff.

3. *Costs of Corporate Acquisitions.*—Costs related to the acquisition of the capital stock of a provider, whether or not such facilities are participating or subsequently will participate in the Medicare program, are not allowable (see § 2134.11). Additionally, costs connected with the transfer of assets to a chain are not allowable as organization costs but instead must be capitalized as part of the cost of the asset (see § 104.10).

C. *Interest on Loans Between Home Office and Components of Chain.*—Where the home office makes a loan to, or borrows money from, one of the components of the chain, the interest paid is generally not an allowable cost and the interest income earned from such a loan is not used to reduce allowable interest expense (see § 218 for the general rule and §§ 218.2 and 220 for exceptions to the general rule). Of course, interest income from other sources, as well as the interest income received by the home office where interest expense is allowed under the exceptions of §§ 218.2 and 220, should be treated under the provisions of §§ 222.2 or 224.2.

APPENDIX H.

Opinion.

AMI-Chanco, Inc., etc. v. The United States. No. 51-75.

United States Court of Claims.

May 17, 1978.

Robert A. Klein, Los Angeles, Cal., for plaintiff: Weissburg & Aronson, Inc., Los Angeles, Cal., of counsel.

Arlene Fine, Washington, D.C., with whom was Asst. Atty. Gen. Barbara Allen Babcock, Washington, D.C., for defendant.

Before COWEN, Senior Judge, NICHOLS and BENNETT, Judges.

ON THE PARTIES' CROSS-MOTIONS FOR SUMMARY JUDGMENT

COWEN, Senior Judge:

Plaintiff, AMI-Chanco, Inc. (Chanco) is a California public corporation which manages over 20 hospitals participating in the Medicare program. On this appeal plaintiff seeks summary judgment for the amount of $260,355 in "stock maintenance costs" for its three fiscal years 1969, 1970 and 1971, on the ground that these are indirect costs of patient care and are thus reimbursable to plaintiff under 42 U.S.C. §§ 1395f(b)[1] and 1395x(v)(1)(A)[2] (Supp. V 1975).

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[1]The section provides:

"The amount paid to any provider of services with respect to services for which payment may be made under this part shall * * * be * * * (A) *the reasonable cost* of such services, as determined under section 1395x(v) of this title * * *" (Emphasis added.)

[2]The section provides:

"The reasonable cost of any services shall be *the cost actually incurred*, excluding therefrom any part of incurred cost found to

(footnote continued on following page)

Plaintiff's fiscal intermediary, the Blue Cross Association, denied plaintiff's claim for reimbursement of these costs, and the intermediary's Medicare Provider Appeals Committee upheld that decision. Plaintiff argues that the Medicare Provider Reimbursement Manual guidelines, on which the fiscal intermediary grounded its decision, are arbitrary and capricious in light of the statutory directives and pertinent regulations. For the reasons to be set forth[3] we agree with plaintiff's contentions and hold that plaintiff is entitled to recover the proportion of its stock maintenance costs which is properly allocable to the Medicare patients served by its member hospitals during the 3 years in issue.

I.

We will not elaborate on the various rights and obligations of providers of Medicare services. For a general discussion in this regard, see our decisions in *Whitecliff v. United*

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be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services * * * Such regulations shall (i) take into account both *direct and indirect costs* of providers of services * * * in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter *will not be borne by individuals not so covered*, and the costs with respect to individuals not so covered will not be borne by such insurance programs * * *" (Emphasis added.)

[3] In light of this disposition of the case, we need not reach two other difficult issues raised by the plaintiff. The first involves the retroactive application of the pertinent Provider Reimbursement Manual guidelines to the years in question. The delicate balancing test which may come into play in the resolution of such an issue is discussed at some length in *Summit Nursing Home, Inc. v. United States*, 215 Ct.Cl. ..... 572 F.2d 737 (1978). The second issue, whether the Provider Reimbursement Manual guidelines applied by the fiscal intermediary are substantive rules rather than interpretative rules, such that plaintiff was not afforded the proper procedural protections provided under the Administrative Procedure Act, presents a frequently discussed problem, most recently addressed by this court in *Gosman v. United States*, 215 Ct.Cl. ..... 573 F.2d 31 (1978).

States, 210 Ct.Cl. 53, 536 F.2d 347 (1976), *cert. den.* 430 U.S. 969, 97 S.Ct. 1652, 52 L.Ed.2d 361 (1977); *Overlook Nursing Home, Inc. v. United States*, 556 F.2d 500, 214 Ct.Cl. 60 (1977); *Ulman v. United States*, 558 F.2d 1, 214 Ct.Cl. 308 (1977); *St. Elizabeth Hospital v. United States*, 558 F.2d 8, 214 Ct.Cl. 322 (1977); and *Summit Nursing Home, Inc. v. United States, supra*, note 3.

As we indicated above, the costs in issue here are labeled "stock maintenance costs" for Medicare reimbursement purposes by the H.E.W. Provider Reimbursement Manual. They include: (1) costs of reports to shareholders and costs of shareholders' meetings; (2) proxy costs, stock transfer fees, and stock exchange registration fees, and (3) accounting and legal fees incurred in connection with requirements of the Securities and Exchange Commission.[4] The issue we decide today involves the validity of two sections of the Provider Reimbursement Manual, which were adopted by the Social Security Administration during 1973:

(1) Section 2134.9, which read:

> The following types of costs relevant to the proprietary and equity interests of the stockholders, but not related to patient care, are excluded from allowable costs: costs incurred primarily for the benefit of stockholders or other investors, including, but not limited to, the costs of stockholders' annual reports and newsletters, annual meeting, mailing of proxies, stock transfer agent fees, stock exchange and registration fees, stockbroker and investment analysis, and accounting and legal fees for consolidating statements for SEC purposes.

(2) Section 2150.2B, which read:

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[4]Stock maintenance costs also include "acquisition costs of new facilities." Plaintiff, however, has advised us that acquisition costs are not in issue in this proceeding, and we hereby specifically exclude such costs from our holding in this case.

> Costs relating to "corporate stock maintenance," including but not limited to costs of annual reports and newsletters to stockholders, annual meetings, mailing of proxies, stock transfer agent fees, stock exchange registration fees, stockbroker and investment analysis, accounting and legal fees for consolidating statements for SEC purposes * * * are not allowable.[5]

Plaintiff argues, and we agree, that these two provisions are arbitrary, capricious and not in accordance with law, and therefore that there was no rational basis for the disallowance of the claimed costs.

II.

We find that H.E.W. acted arbitrarily in adopting and enforcing the provisions in question because they are not consistent with the basic objectives of the enabling legislation, with other Medicare regulations adopted pursuant to that legislation, or with other government regulations which allow the same costs in other contexts.

A. *The enabling legislation.*

Congress had directed that Medicare providers should be reimbursed for the indirect costs of patient care. 42 U.S.C. § 1395x(v)(1)(A)(i) (Supp. V 1975). The Secretary of H.E.W. has appropriately promulgated interpretative regulations which recognize that allowable costs include those "which are *appropriate and helpful* in developing and maintaining the operation of patient care facilities and activities * * [and] are usually costs which are common and accepted occurrences in the field of the provider's activity." (Emphasis added.) 20 C.F.R. § 405.451(b)(2) (1977). There

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[5]Section 2150.2B also disallowed reimbursement for certain "capital expenditures" such as "costs incident to reorganization." These costs are not in issue in this proceeding, however, and we render no opinion on the validity of their disallowance.

are several reasons for our holding that the statute and the regulations contemplated reimbursement for stock maintenance costs. First, a corporate provider of services, such as Chanco, is expressly recognized as an acceptable provider of services under H.E.W. interpretation of the Act. 20 C.F.R. §§ 405.429(a)(2) and 405.603(b) (1977). Next, as a public corporation operating in California, Chanco is required by state and federal securities law to incur stock maintenance costs as part of its operating budget: those costs are necessarily incurred in providing services to Medicare patients. California law also demands that Chanco hold an annual meeting of shareholders to elect directors of the corporation, and to send an annual report to shareholders within 20 days after the close of its fiscal year. California Corporations Code §§ 301, 1501. Federal securities law requires Chanco as a public corporation to incur various accounting, legal, printing, and other fees in order to meet the requirements of the Securities Act of 1933, 15 U.S.C. §§ 77a-77aa (1976), and the Securities Exchange Act of 1934, 15 U.S.C. § 78a *et seq.* (1976). The government defends its disallowance of the above legally mandated costs on the ground that they are costs incurred solely for the benefit of investors. It may be that these laws were enacted for the benefit of investors, but the fact remains that Chanco must legally incur these costs in order that it may attract the equity capital which is necessary for its operation of facilities to provide patient care services. Thus to the extent that Chanco provides services to Medicare recipients, these stock maintenance costs are indirect costs of serving these patients.

The Provider Reimbursement Manual provisions in question also conflict with the statutory directive that costs of treating Medicare patients not be shifted to the non-Medicare hospital population. 42 U.S.C. § 1395x(v)(1)(A). The legislative history illuminates the reasons for that provision:

> * * * we don't want to set up a program here that is going to pay 90 percent of the costs of these people, and the rest of the folks * * * have 10 percent added to their hospital costs at the same time. That wouldn't be fair to the public. I don't think there is any argument about that.

Comments of Chairman Wilbur Mills, Medical Care for the Aged, Executive Hearings before the Committee on Ways and Means, House of Representatives, 89th Cong., 1st Sess. (1965), vol. 1, at 417. Yet, if the costs in issue are finally disallowed, Chanco will be compelled to collect from its non-Medicare patients stock maintenance costs which are justly attributable to the cost of treating Medicare patients.

B. *Other Medicare regulations.*

The Manual provisions in question are also not consistent with other Medicare regulations adopted pursuant to the enabling legislation. Such other regulations permit reimbursement for costs which are either very similar to or are generally inclusive of the costs defined by H.E.W. as stock maintenance costs. They include: (1) general administrative and accounting costs, (2) costs of corporate organization, (3) costs of annual meetings and reports when incurred by nonprofit corporations, (4) costs of attracting equity capital, and (5) costs of corporate financing.

1. *General administrative and accounting costs.*

The stock maintenance costs which Chanco has incurred have been identified by accountants as part of a corporation's general and administrative expense. *See* Simons & Karrenbrock, Intermediate Accounting, 4th Ed., at 34. Thus, they would appear to be reimbursable under a Medicare regulation which provides for payment of costs determined in accordance with "standardized definitions, accounting, sta-

tistics, and reporting practices which are widely accepted in the hospital and related fields * * *.'' 20 C.F.R. § 405.406(a) (1977).

2. *Costs of corporate organization.*

In its Provider Reimbursement Manual, H.E.W. has authorized reimbursement of costs of corporate organization, including legal and accounting fees, directors' fees, incorporation fees, expenses of organization meetings of directors and stockholders, and other costs required to create the corporate entity. HIM-15 § 2134.1A. We fail to perceive any rational basis for treating the costs of creating a corporate entity as allowable, indirect expenses of patient care, while disallowing stock maintenance costs that are essential to the maintenance of the corporate organization.

3. *Annual meetings and reports of non-profit corporations.*

There is no provision in the Medicare regulations which denies nonprofit corporations reimbursement for the costs of annual meetings and reports—the same costs which are denied to profit-making corporations such as Chanco. The reports by nonprofit providers of medicare services are indistinguishable, in substance, from reports required by the SEC with respect to publicly held investor-owned corporations. It is difficult to escape the conclusion that H.E.W.'s disparate treatment is arbitrary, especially when one considers that corporate providers of medical care are encouraged by the Medicare regulations to treat Medicare patients. *See* 20 C.F.R. §§ 405.429(a)(2) and 405.603(b) (1977). Furthermore, the distinction made by H.E.W. collides with another Medicare regulation which prohibits inequitable application of cost reimbursement principles between nonprofit organizations and profit-making organizations. 20 C.F.R. § 405.402(b)(5) (1977).

4. *Costs of attracting equity capital.*

The enabling statute and pertinent regulations make it the policy of the Medicare program to attract investment capital to corporate providers of Medicare services. The Act provides for a return on investment as follows:

> Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. * * *

42 U.S.C. § 1395x(v)(1)(B) (Supp. V 1975).

Regulations adopted pursuant to this provision recognize that a "return on investment * * * is needed to avoid withdrawal of capital and to attract additional capital needed for expansion." 20 C.F.R. § 405.429(b)(1) (1977).

By directing that corporate providers shall receive a reasonable return on equity capital, Congress has declared that it considers a reasonable return on investment to be one of the costs of patient care which is reimbursable under the Act. Surely, if Congress meant to bolster the effectiveness of the Medicare program by offering the incentive of a return on equity to investors of capital, it also intended to provide reimbursement for stock maintenance costs, which by their very definition are essential elements of the process of attracting the equity capital necessary to provide patient care services. In fact, it is a contradictory policy which encourages the attraction of investment capital but disallows the costs of doing so, on the grounds that the latter costs are not related to patient care.

5. *Costs of corporate financing.*

Pertinent Medicare regulations also reimburse other methods of corporate financing. Interest paid on bonds and notes is an allowable cost. Provider Reimbursement Manual HIM-

15 §§ 212-212.3. Expenses incurred in connection with bond issuances, including professional fees, underwriters' fees, appraisers' fees, printing costs, and other similar costs, are also defrayed. *Id.* Obviously, these provisions evidence a policy within H.E.W. to permit reimbursement for debt financing as an appropriate cost of providing Medicare services. Yet, it is a basic principle of obtaining debt financing that the greater an amount of equity capital a corporation has in relation to its debt, the less it pays to borrow funds. *See* Nemmers & Grunewald, Basic Managerial Finance, 2d Ed. (1975), at 379. And, as we have noted previously, stock maintenance costs are among those costs necessarily expended in attracting equity capital—so much so that the law requires that they must be incurred by an investor-owned corporation such as plaintiff. It follows that in order to obtain the best possible debt financing, plaintiff cannot avoid expenditures for stock maintenance.

In a decision of September 2, 1977, the Provider Reimbursement Review Board ruled in an appeal by another provider, American Medical International, that stock maintenance costs are allowable. The decision stated in part:

> Furthermore, loan agreements between the Parent Company and its lenders contain a covenant with the lender that the Parent Company will maintain its corporate status, rights, privileges and franchises. These are common covenants of major borrowings which are inserted for the protection of the lender to insure that the corporate status will not materially change during the term of the loan. Lenders are concerned that large borrowers continue to maintain their stock on the public market to insure the integrity of the equity cushion underlying the loan. Each of the costs which have been identified as stock maintenance costs would be required to be incurred as a condition to satisfying the loan agreements, and since costs associated with borrowings

> have clearly been allowed by the program, no distinction should be made with respect to the costs in issue here.[6]

In summary, we conclude the refusal to pay stock maintenance costs is incompatible with the above-discussed regulations which authorize the reimbursement of corporate debt financing.

C. *Other federal agency regulations.*

Although it is not a controlling factor, the treatment accorded in the regulations of other agencies to expenses of the kind involved here, lends support to plaintiff's position. For example, the Commissioner of Internal Revenue has ruled that certain stock transfer fees and costs of maintaining stockholder records are deductible from taxable income as ordinary and necessary business expenses. In reaching his conclusion, the Commissioner explained as follows:

> Although a corporation is formed primarily to engage in a particular business, *the corporate organization must be maintained in order to carry on the business* for which it is formed. This involves the holding of meetings of the stockholders to elect the officers through which the corporation acts and to vote on matters that require stockholders' sanction. *For such purpose proper records* showing the names and addresses of the stockholders *must be maintained.* (Emphasis added.

Rev. Rul. 69-615, 1969-2 C.B. 26.

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[6]Decision No. CN 75-1426 at 23; attached as Exhibit II to Defendant's moving brief. Although defendant has informed the court that the Administrator of the Health Care Financing Administration of H.E.W. reversed the Board's decision on November 4, 1977 (Defendant's Reply Brief at p. 2), we agree with the Board's reasoning and the result it reached.

Also, in the area of government procurement, it is the policy of the government to approve or otherwise sanction such costs on the ground that they are part of the corporation's general and administrative costs. *Northrop Aircraft Co.*, (1950) B.C.A. 76, Government Contracts Report, para. 60,869; or are indirect costs subject to reimbursement, Armed Services Procurement Regulations § 15-205.24; or are "reasonable costs" for purposes of payment to suppliers to the federal government, Federal Procurement Regulations § 1-15.205.24.

III.

We are congnizant that:

> * * * A court has no warrant to set aside agency action as arbitrary or capricious when those words mean no more than that the judges would have handled the matter differently had they been agency members. Judicial intervention must, instead, be rested upon a demonstration that the agency action has transgressed the statutory boundaries * *.

Calcutta E. Coast of India & E. Pakistan/U.S.A. Conf. v. Federal Maritime Commission, 130 U.S.App.D.C. 261, 264, 399 F.2d 944, 997 (1968). The government cites two prior decisions of this court, *Zachry Co. v. United States*, 344 F.2d 352, 170 Ct.Cl. 115, (1965); and *Schellfeffer v. United States*, 343 F.2d 936, 170 Ct.Cl. 178 (1965), to remind us that administrative interpretations of a statute are entitled to great weight and are not to be ignored unless unreasonable. The government further informs us that Congress has granted the Secretary broad discretion to formulate regulations under the Medicare Act. *Springdale Convalescent Center v. Mathews*, 545 F.2d 943, 951 (5th Cir. 1977). We think that our decision today is not inconsistent with the cited cases. In *Springdale Convalescent Center*, the Fifth Circuit declared that "the Secretary's discretion is not un-

fettered." *Id.* at 952.

It is not often that we face circumstances so compelling that the ends of justice persuade us to characterize an administrative decision as arbitrary or capricious. However, we find that the decision in this case is so inconsistent with the statutory purpose and other regulations of the same agency that we cannot uphold that decision. Although "stock maintenance expenses" are a special classification coined by H.E.W., we find that they are actually general and administrative expenses, which are indirectly related to and necessarily incurred in providing the Medicare services involved in this case.

The basis for our decision has precedent in the decisions of other federal courts which have labeled as arbitrary administrative decisions respecting expenses incurred by providers of Medicare services. *Temple University v. Associated Hospital Services*, 361 F.Supp. 263, 273-74 (D.C.1973); *South Boston General Hosp. v. Blue Cross of Virginia*, 409 F.Supp. 1380, 1385 (W.D.Va.1976). Moreover, we follow the holding of the Supreme Court that an agency construction of a statute will be affirmed only if it "has reasonable basis in law."

> * * * courts * * * "are not obliged to stand aside and rubber-stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute." * * * "The deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia. * * *"

Volkswagenwerk v. Federal Maritime Commission, 390 U.S. 261, 272, 88 S.Ct. 929, 935, 19 L.Ed.2d 1090 (1968); *citing NLRB v. Brown*, 380 U.S. 278, 291, 85 S.Ct. 980, 13 L.Ed.2d 839 (1965); and *American Ship Building Co. v. NLRB*, 380 U.S. 300, 318, 85 S.Ct. 955, 13 L.Ed.2d

855 (1965). See *Morton v. Ruiz*, 415 U.S. 199, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974); *Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S.Ct. 161, 89 L.Ed. 124 (1944). In the final analysis, a prior decision of this court summarizes our conclusion regarding the disposition of this case:

> * * * the * * * Board and the Secretary * * * have not followed * * * the statute; they have not been consistent in their administration of the law, and their decisions are, in part, based upon the application of a regulation in a manner which is repugnant to the provisions of the statute * * *. For these reasons, we reverse the administrative decisions.

Farrell Lines, Inc. v. United States, 499 F.2d 587, 597, 204 Ct.Cl. 482, 498 (1974).

IV.

The government also contends, apparently as an alternative argument, that the statutory provision made by Congress for a return on equity to corporate providers was intended to include reimbursement for stock maintenance costs within the specified percentage rate for a return on equity. In section 1861(v)(1)(B) of the Social Security Act, Congress set the rate of return at not more than 1.5 times the average rate for interest paid on certain obligations issued to the Federal Hospital Insurance Trust Fund.

We find that there is no merit in this belated contention, which was not raised in the administrative proceedings. The government cites no legislative history, documentation, or authority of any kind in support of this proposition. Its argument is based almost solely on its unsupported interpretation of the provision in 42 U.S.C. § 1395x(v)(1)(B) (Supp. V 1975) that a reasonable return on equity is to be paid "in lieu of other allowances to the extent that they reflect similar items." The government says that stock main-

tenance costs are such "other allowances." In the absence of any legislative history to the contrary, we find that a plain reading of the statute indicates that the payment of the return on equity capital is in lieu of other "similar" payments *for the use of capital*. Reimbursements for stock maintenance costs are not similar to payments for use of capital.

That the government's position is legally erroneous is, we think, clearly demonstrated in the following excerpt from the decision of September 2, 1977, by the Provider Reimbursement Review Board in the *Appeal of American Medical International*.[7]

> Moreover, the rate of return is a market concept, which varies with market conditions while most stock maintenance costs are fixed costs impervious to market variances. The effect of including a fixed cost within a variable market rate will cause the rate of return to vary from the market rate in differing proportions. Since both the Medicare Law and the Regulations provide that the rate of return will be tied to 150 percent of the yields on loans of the Federal Hospital Insurance Trust Fund, it clearly violates that Law and Regulation to offset a part of that return by disallowing stock maintenance costs. [Defendant's Exhibit II, pp. 24-25.]

Furthermore we find unconvincing the government's argument that Congress demonstrated its intention to reimburse stock maintenance costs as part of the rate of return on equity by not enacting the section providing for a rate of return until a year or so after the original Medicare legislation was passed. If the delay in enactment of section 1395x(v)(1)(B) means anything at all, we think it indicates a Congressional intent that the rate of return on equity capital

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[7] Note 6, *supra*.

was to be allowed, wholly apart from and independent of other indirect costs, such as stock maintenance costs, which were covered by previously enacted legislation.

V.

For the reasons set out above, plaintiff's motion for summary judgment is granted, defendant's cross-motion for summary judgment is denied, and the case is remanded to the trial division for a determination of the amount plaintiff is entitled to recover in accordance with this opinion.

APPENDIX I.

Memorandum of Decision.

In the United States Claims Court.

No. 345-81C — (Filed: March 30, 1984).

Alexander Hospital, Inc. et al. v. The United States.

Medicare, Part A: Reimbursements: Stock Maintenance Costs: Collateral Estoppel.

Michael H. Cook, Washington, D.C., attorney of record for plaintiffs. *Dennis M. Barry*, *Michael J. Mannedi*, and *Wood, Lucksinger & Epstein*, Washington, D.C., of counsel.

Lorraine B. Halloway, with whom was *Acting Assistant Attorney General Richard K. Willard*, for defendant.

MEMORANDUM OF DECISION

HARKINS, *Judge*.

Plaintiffs' petition (now complaint) was filed in the United States Court of Claims on May 26, 1981, to recover unreimbursed costs for supplying health care services under Part A of the Medicare Program (Hospital Insurance Benefits for the Aged and Disabled). 42 U.S.C. §§ 1395c-1395i-2 (1983). Plaintiffs' case was transferred to this court pursuant to section 403(d) of the Federal Courts Improvement Act of 1982. 28 U.S.C.A. § 171 note (1983). The case is before the court on cross-motions for summary judgment, and oral argument was heard on July 27, 1983. For the reasons that follow, plaintiffs' motion for summary judgment is allowed and defendant's motion is denied.

Defendant filed a motion to dismiss on June 15, 1982, based on the contention that the United States Court of Claims lacked jurisdiction under the Tucker Act by reason of the decision in *United States v. Erika, Inc.*, 456 U.S. 201 (1982). At argument, defendant stated that the motion to dismiss was not being pressed in this case.

The material facts are not in controversy. The 40 plaintiffs listed in the complaint include American Medical International, Inc. (AMI), and 39 hospitals, which are wholly owned, either directly by AMI or by its wholly owned subsidiary American Medical (Central), Inc. AMI is a publicly traded corporation and is one of the largest hospital chain organizations in the United States that provide Medicare health care services. At all times relevant, each plaintiff except AMI was a hospital provider of services pursuant to a contract with the Secretary of the Department of Health, Education and Welfare (HEW) (redesignated in 1980 as the Department of Health and Human Services (HHS)). 42 U.S.C. §§ 1395cc(a)(1), 1395x(e), 1395x(v) (1983).

Plaintiffs' claims are for reimbursement of stock maintenance costs incurred during fiscal years 1969 through 1973. Stock maintenance costs include: (1) accounting costs relating to Securities and Exchange Commission (SEC) filings; (2) other SEC filing costs; (3) stock transfer fees; (4) stock exchange regulation fees; and (5) expenses relating to the accounting and legal expenses of compilation of annual reports, confirming share holders meetings and proxy costs. The stock maintenance costs for plaintiffs in this case are claimed to total $1,097,818 for fiscal years 1969-73. The administrative record is not clear on this point and this decision is limited to the issue of whether the costs claimed are allowable.

This case is an incident in the protracted battle between publicly traded chain hospital organizations and the HEW and HHS as to the reimbursability of stock maintenance costs. This ongoing dispute has resulted in conflicting decisions by the former United States Court of Claims on the one hand, and the United States Court of Appeals for the District of Columbia Circuit and the Fifth Circuit on the other. The various cases have involved differing accounting

years, and a time span that includes procedural changes in administrative appeals and judicial review of provider reimbursement claims for account periods ending on and after June 30, 1973.

The Medicare Act did not provide a formal administrative review of provider reimbursement claims arising on or prior to June 30, 1973, claims such as are involved in this case. The regulations, however, require the "fiscal intermediary" to provide a review hearing where the amount in controversy exceeds $1,000. 42 C.F.R. § 405.1809. Disallowances by plaintiffs' fiscal intermediary were appealed to a Hearing Officer, who is an employee of the fiscal intermediary that made the adjustment (42 C.F.R. § 405.1811) and then a "Special Review Officer" in the Health Care Financing Administration (HCFA) on behalf of the Secretary. The decision of the HCFA constitutes the Secretary's final administrative action for purposes of judicial review. For claims arising after June 30, 1973, appeals from the determinations of a fiscal intermediary are to the Provider Reimbursement Review Board (PRRB), if the amount in controversy is at least $10,000. Judicial review of decisions of the PRRB is obtained through an appeal to the district court in which the provider is located or in the District Court for the District of Columbia. 42 U.S.C. § 1395oo (1983); 42 C.F.R. §§ 405.1835 et seq.

It is not necessary to elaborate on the various rights and responsibilities of providers of Medicare services. For a general discussion of the Medicare Program *see*: *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (Ct.Cl. 1976), *cert. denied*, 430 U.S. 969 (1977); *St. Elizabeth Hosp.* v. *United States*, 558 F.2d 8 (Ct.Cl. 1977); *American Med. Int'l., Inc.* v. *Sec. of H.E.W.*, 466 F. Supp. 605 (D. D.C. 1979); *Sun Towers, Inc.* v. *Heckler*, 725 F2d. 315 (5th Cir. 1984).

The substantive issues involved in reimbursability of stock maintenance costs have been examined in detail by the courts involved. On May 17, 1978, the Court of Claims in *AMI-Chanco, Inc.* v. *United States*, 576 F.2d 320 (Ct.Cl. 1978) determined that the stock maintenance costs for fiscal years 1969, 1970 and 1971, were reimbursable under the Medicare Program. *AMI-Chanco* involved 20 hospital participants in the Medicare Program, and the ruling for fiscal years 1969-72 in that case applies to 20 plaintiffs in the instant case.

In *AMI-Chanco*, the Court of Claims decided that the two sections of the Provider Reimbursement Manual (PRM), sections 2134.9 and 2150.2B which had been adopted in 1973, were arbitrary, capricious, not in accordance with law, and afforded no rational basis for disallowance of the claimed costs. 576 F.2d at 322. These sections had been applied by the fiscal intermediary and the HCFA to exclude stock maintenance costs from reimbursement. HEW was found to have acted arbitrarily in adopting and enforcing these provisions because they were not consistent with the basic objectives of the enabling legislation and other Medicare regulations. Stock maintenance costs, also, were found not to be incurred solely for the benefit of investors, but were costs legally required to be incurred in order to attract equity capital. Stock maintenance costs were designated indirect costs of serving Medicare patients. PRM §§ 2134.9 and 2150.2B were held to be inconsistent with other Medicare regulations which permit reimbursement for costs similar to, or generally inclusive of, the costs defined as stock maintenance costs, *i.e.* general administrative and accounting costs, costs of corporate organization, costs of annual meetings and reports when incurred by nonprofit corporations, costs of attracting equity capital, and costs of corporate financing. The Court of Claims took cognizance of

the case law restricting judicial intervention in agency action, acknowledged that the administrative interpretation of a statute is entitled to great weight, and that Congress granted the Secretary broad discretion to formulate regulations under the Act. Notwithstanding these established principles, however, the Court of Claims concluded that it could not uphold the decision on stock maintenance costs because the agency decision was "inconsistent with the statutory purpose and other regulations" and followed the principle that an agency construction of the statute need be confirmed only "if it has a reasonable basis in law," *citing Volkswagenwerk* v. *Federal Maritime Comm'n*, 390 U.S. 261, 271 (1968), 576 F.2nd at 326.

On February 2, 1979, the District Court for the District of Columbia in *American Medical International, Inc.* v. *Secretary of Health, Education and Welfare*, (466 F. Supp. 605 (1979)) (hereinafter *AMInt'l*) determined that stock maintenance costs for fiscal years June 30, 1973 through November 30, 1975, are not reimbursable under the Medicare Act because they are not reasonable costs necessary for providing patient care. The decision in *AMInt'l* involved 38 provider hospitals, 34 of which are plaintiffs in the instant case. In its opinion, the district court concluded that, while stock maintenance costs are necessary for a corporation to exist, Medicare services can be provided without the corporate form. Such costs all were found to be directed at benefiting investors, and that their relationship to the provision of health care is too remote to be considered reasonable costs necessary for providing such care. The district court examined the provisions and legislative history that allow proprietary providers an equitable return on capital (42 U.S.C. § 1395x(v)(1)(B) (1983)) and concluded that the provisions could not be used to support the position that the term "reasonable costs" was meant to include costs for

investment. The district court also concluded that there was no inconsistency in the Secretary's decision to reimburse stock maintenance costs of nonprofit corporations, while denying such reimbursement to for-profit corporations. The district court found that the primary purpose of annual meetings, filings, etc. of for-profit corporations is to enhance investments and not to provide improved medical care. The "primary purpose" test adopted by HCFA was found to be reasonable. The district court further found that, inasmuch as stock maintenance costs were not "necessary costs of rendering services," the failure to reimburse such costs did not shift the cost to non-Medicare patients. 466 F. Supp. at 615. The district court also found that PRM §§ 2134.9 and 2150.2B were "interpretative rules" which were excluded from the requirements of the Administrative Procedure Act relative to notice and opportunity to comment. 466 F. Supp. at 616.

On August 14, 1981, the Court of Appeals for the District of Columbia affirmed the district court's decision in *AMInt'l*. 677 F.2d 118 (D.C. Cir. 1981). The court of appeals agreed that the stock maintenance costs at issue were not reimbursable because they were not necessarily incurred in the provision of health care services to Medicare patients. Because the district court had not addressed the issue of whether the prior decision in *AMI-Chanco* by the Court of Claims collaterally estopped the Administrator from withholding reimbursement on stock maintenance costs, the court of appeals examined in detail the "difficult and troubling aspects of the law of issue-preclusion."

The court concluded that special circumstances existed that warranted exception to the normal rules of collateral estoppel. It noted that *AMI-Chanco* involved stock maintenance costs incurred in fiscal years 1969, 1970 and 1971 and that those involved in *AMInt'l* were costs incurred on

or after June 30, 1973. The court found unpersuasive defendant's contention that only *AMI-Chanco* was involved in the initial suit because it was not bound by the more technical aspects of the privity doctrine. 677 F.2d at 120 n. 9. The unusual circumstances that warranted refusal of collateral estoppel was the fact that "A federal agency, not a private party, lost on an issue of federal law, not an issue of fact, in the first law suit." It further stated "to allow nonparties to the Court of Claims' ruling to win simply on the basis of an estoppel would mean that we simply and uncritically bind ourselves to follow another court's interpretation of a federal statute in virtually all cases involving that legislation." 677 F.2d at 121. The court concluded that such a holding, in cases raising a public law issue litigable only with the Federal Government, if the Government lost, would rigidify the law. In order to preserve the benefits that are derived from conflicts among the circuits, the court of appeals concluded that no collateral estoppel should arise in the particular circumstances. The court observed that while courts of appeal consistently recognize the importance of uniformity "they have never considered themselves hidebound by other circuits on legal questions involving federal-agency defendants." 677 F.2d at 123.

On July 30, 1982, the United States District Court for the Western District of Texas in *Sun Towers, Inc.* v. *Schweiker* (No. P-80-CA-16) ruled that stock maintenance costs for fiscal year 1973 were reimbursable. Plaintiffs were the Hospital Corporation of American (HCA) and 47 hospital subsidiaries. The district court found that HCA was required by law to undertake the activities that give rise to the costs and that, if it did not comply, it could not engage in business and provide hospital care to patients. The district court concluded that, with respect to the stock maintenance costs, the plaintiffs had discharged the burden of showing the

Secretary's decision to disallow such costs was arbitrary, capricious and contrary to law.

On appeal (*Sun Towers, Inc.* v. *Heckler*, 725 F.2d 315 (5th Cir. 1984)), the Fifth Circuit reversed on the stock maintenance cost issue. In an extended discussion of collateral estoppel, the court noted the discussion that attended the ruling in *United States* v. *Mendoza* (52 U.S.L.W. 4019 (U.S. Jan. 10, 1984)) that nonmutual collateral estoppel is not to be extended against the United States. To allow nonmutual collateral estoppel against the Government would substantially thwart the development of important questions of law by freezing the first final decision rendered on a particular issue. The Fifth Circuit accepted the admonition to allow thorough development of legal doctrine by litigation in multiple forums and held that the use of nonmutual collateral estoppel against the Secretary was foreclosed. On the merits of reimbursability of stock maintenance costs, the Fifth Circuit differed with the conclusion of the Court of Claims that the Government's disallowance of these costs was arbitrary and capricious. The Fifth Circuit did not believe the Secretary's interpretation was irrational or unreasonable. The court also differed with the Court of Claims because "we do not believe that the primary purpose test the Secretary utilized here is unreasonable or irrational." *Sun Towers, Inc.*, 725 F.2d at 328.

On August 19, 1982, the District Court for the District of Columbia in *Humana, Inc.* v. *Schweiker* (Nos. 75-0302, 78-0175, 78-0584, 81-0853 and 81-1311) ruled that stock maintenance costs incurred by Humana, Inc. and 64 of its subsidiary hospital corporations for fiscal years 1973-77, and to some extent for a period prior to 1973, were not reimbursable. The district court ruled that the decision in *AMInt'l* foreclosed any claim in that circuit that stock maintenance costs were necessary to provide health care services.

the district court noted that the court of appeals' affirmation of the lower court in *AMInt'l* specifically addressed the issue of whether the Secretary was estopped from withholding reimbursement of stock maintenance costs given in *AMI-Chanco* and found that it was not bound by the Court of Claims decision.

On January 25, 1984, in a case involving Humana, Inc. and 37 wholly owned subsidiary hospital corporations (*Brentwood Hosp., Inc.* v. *United States*, ___ Cl.Ct. ___ (No. 614-82C, op. Jan. 25, 1984), this court (*White*, Senior Judge) decided that stock maintenance costs for fiscal years 1971 and 1972 were not reimbursable. The court concluded that Humana was barred by the doctrine of collateral estoppel from relitigating in this court the stock maintenance issue, because it had been argued and rejected in the August 19, 1982, decision of the district court.

Action at the administrative level, which preceded the foregoing court rulings on the reimbursability of stock maintenance costs, reflects persistent conflict on whether such costs are reimbursable, and an aggressive pursuit by the parties involved of their respective positions. In *AMI-Chanco*, the fiscal intermediary denied the claims for reimbursement of 1969-71 costs, and the denial was upheld by the Medicare Provider Appeals Committee, before plaintiffs appealed to the Court of Claims in 1975. In *AMInt'l*, the fiscal intermediaries' determinations that the post-June 30, 1973, costs were not reimbursable were appealed to the PRRB that had been created by the 1972 amendments. 42 U.S.C. § 1395oo(b) (1983). The PRRB on September 8, 1977, reversed. On November 4, 1977, the HCFA Administrator reversed the PRRB and reinstated the fiscal intermediaries' determinations on nonreimbursability of stock maintenance costs. Pursuant to the 1974 changes in judicial review procedures, appeal to the United States District Court

for the District of Columbia followed. 42 U.S.C. § 1395oo(f) (1983).

In the *Sun Towers, Inc.* cases, the fiscal intermediaries disallowed the post-June 30, 1973, costs, which decision was reversed by the PRRB on January 2, 1980. On March 6, 1980, the Deputy Administrator reversed and disallowed the stock maintenance costs, and the appeal to the District Court for the Western District of Texas followed.

In the cases involving Humana, Inc., the fiscal intermediaries in two cases disallowed stock maintenance costs for the period ending August 31, 1973, which decisions were reversed by the PRRB on December 1, 1977. Subsequently, on January 31, 1978, the Administrator reversed that portion of the PRRB decision applicable to the August 31, 1973, cost period. In later proceedings involving other hospitals, the PRRB decided that Humana's claims for stock maintenance costs for fiscal years ending 1974 and 1975 were reimbursable. The Administrator failed to take timely action to reverse the PRRB decision for the 1974 and 1975 cost years, and the PRRB decision for those years for the hospitals involved was the final agency action in the district court proceedings. For cost years 1976 and 1977, the Administrator timely reversed the PRRB and denied the claims for reimbursement of stock maintenance costs. Similarly, the Administrator disallowed the claims for 1971 and 1972 cost years, which were the basis for the *Brentwood* case filed in the Claims Court on December 1, 1982.

In this case, plaintiffs' stock maintenance costs for various fiscal periods ending June 30, 1968, through May 31, 1973, were disallowed by the fiscal intermediaries on the basis of PRM §§ 2134.9 and 2150.2B, which were issued in 1973, subsequent to the commencement of the last cost reporting period involved. Because the periods in dispute ended prior to June 30, 1973, appeal was to the interme-

diaries' hearing officer. The BCA hearing officer incorporated into his record: the PRRB decision of June 8, 1977, for cost years June 30, 1973 to November 30, 1975; the Administrator's November 4, 1977, reversal of the PRRB, and the February 2, 1979, district court decision in the *AMInt'l* case. On June 23, 1980, plaintiffs were notified that the BCA hearing officer had denied reimbursement for stock maintenance costs.

On August 18, 1980, plaintiffs requested review of the BCA hearing officer's decision. By letter dated November 10, 1980, they were informed that the review would be delayed pending decision by the court of appeals in the *AMInt'l* case. Plaintiffs filed this action in the United States Court of Claims on May 26, 1981. On November 30, 1981, after a delay of 15 months, the special review officer of HCFA affirmed the BCA hearing officer's decision, on the basis of the November 4, 1977, Administrator's decision.

Plaintiffs assert that both the Claims Court and the Court of Appeals for the Federal Circuit are bound by the precedent of the Court of Claims in *AMI-Chanco*. Defendant concedes that, if this court reaches the substantive merits of the stock maintenance cost issue, by the rules of this court and of the Federal Circuit, the decision in *AMI-Chanco* controls. General Order No. 1, 1 Cl.Ct. XXI (1982); *South Corp. v. United States*, 690 F.2d 1368 (Fed. Cir. 1982). Defendant contends, however, that, under the doctrine of collateral estoppel, the decision of the D.C. circuit in *AMInt'l* for post-June 30, 1973-75 costs precludes relitigation of entitlement to Medicare reimbursements for cost years prior to June 30, 1973. Plaintiffs reply that defendant's position is outrageous on the facts, and a misuse of subsequent contrary precedent of another circuit. Plaintiffs argue that collateral estoppel, as an equitable doctrine to be applied at the court's discretion dependent upon the facts and circumstances in-

volved in this particular case, should not be misused so as to preclude reimbursement for the pre-June 30, 1973, stock maintenance costs at issue.

The arcane intricacies of the doctrine of collateral estoppel have been explored in detail by the courts that have considered the issue of Medicare reimbursement for stock maintenance costs of proprietary hospitals. *See generally Baldwin Park Com. Hosp. v. United States*, ___ Cl.Ct. ___ (No. 518-79C, op. Jan. 25, 1984); *AMInt'l*, 677 F.2d at 119-24; *Sun Towers, Inc.*, 315 F.2d at 322-23. Further exploration at this stage would not produce new or different fruit. It is sufficient therefore to summarize the conclusions that apply to this decision.

Recent Supreme Court decisions establish the scope of the collateral estoppel doctrine. Under collateral estoppel, once an issue is actually and necessarily determined by a court of competent jurisdiction, that determination is conclusive in subsequent suits based upon a different cause of action involving a party to the prior litigation. *Parklane Hosiery Co. v. Shore*, 439 U.S. 322, 326 n. 5 (1979). "Mutuality of parties" no longer is necessary in suits between private parties; and "defensive" collateral estoppel is allowed against the Government to preclude it from relitigating a position against the same party to whom it had previously lost. *Id.* at 337; *Montana v. United States*, 440 U.S. 147, 164 (1979). Offensive use of collateral estoppel occurs when a plaintiff seeks to foreclose a defendant from relitigating an issue the defendant has previously litigated unsuccessfully in another action against the same or a different party. Defensive use of collateral estoppel occurs when a defendant seeks to prevent a plaintiff from relitigating an issue the plaintiff has previously litigated unsuccessfully in another action against the same or a different party. *Parklane Hosiery*, 436 U.S. at 326 n.4.

In cases where the Government is involved, mutuality retains its importance and *Parklane's* approval of nonmutual offensive collateral estoppel is not be to extended to the United States because such cases would thwart the development of important questions of law by freezing the first final decision rendered on a particular legal issue. *United States v. Mendoza*, 52 U.S.L.W. at 4022. The doctrine of "mutual" defensive collateral estoppel is applied against the United States to preclude relitigation of the same issue already litigated against the same party in another case and the facts are virtually identical. *United States v. Stauffer Chem. Co.*, (52 U.S.L.W. 4022 (U.S. Jan. 10, 1984)).

In summary, the doctrine of collateral estoppel may be invoked when: (1) the issue as to which the doctrine is asserted was the same in the previous litigation as in the current litigation; (2) the issue was "actually litigated" in the previous case and was necessary and essential to the resulting judgment; (3) there have been no significant changes in the facts or in the applicable legal principles since the initial decision; (4) all the parties as to whom collateral estoppel is asserted were fully represented in the previous action, either directly or through other parties or privies that have related financial or proprietary interests; and (5) there are no special circumstances indicating that the use of collateral estoppel would be inappropriate. *Baldwin Park Com. Hosp. v. United States*, ___ Cl.Ct. ___ (No. 518-79C, op. Jan. 25, 1984).

The legal issue of the reimbursability of stock maintenance costs is the same in this case as it was in *AMI-Chanco* decided by the Court of Claims and, in *AMInt'l* decided by the D.C. Circuit. Thre is no dispute on the facts that relate to incurrence of stock maintenance costs. The facts are not "identical," however, because different cost years are involved: *AMI-Chanco* concerned cost years 1969-71. *AMInt'l*

with cost years July 1973-75, and this case concerns 1969-June 1973 cost years. The current developments in the law of collateral estoppel have extended application of the doctrine to facts that are "substantially" the same where no change in facts is of "controlling significance." *Montana*, 440 U.S. at 159-61. In this case the facts are nearly identical to *AMI-Chanco*. Some of the plaintiffs in this case, who were not in *AMI-Chanco*, have claims for the years there decided; those providers which prevailed in *AMI-Chanco* have claims for other years.

Plaintiffs in this case either were parties in the *AMI-Chanco* case and the *AMInt'l* cases, or are privies that have related financial interests. In *AMInt'l*, the court denied collateral estoppel effect of *AMI-Chanco*, notwithstanding the showing in the administrative record that 23 plaintiffs directly benefited from *AMI-Chanco*. The concept of privies, entities related by financial or proprietary interests, has been recognized for decades. *See Chicago, R.I. & P. Ry. Co. v. Schendel*, 270 U.S. 611, 620 (1926) (substantial identity between parties). It is irrelevant that a plaintiff was not a named party in the prior litigation. *Ma Chuck Moon v. Dulles*, 237 F.2d 241, 243 (9th Cir. 1956), *cert. denied*, 352 U.S. 1002 (1957). *See also* Restatement of Judgments § 83 (1942); Restatement (Second) of Judgments § 41 (1982) (privy includes those whose interests are represented); 1B Moore's Federal Practice ¶ 0.411 [1] at 390 (2d ed. 1983) (privy is a person who accepts benefits). Clearly, the *AMInt'l* plaintiffs were "privy" to the *AMI-Chanco* case. The *AMInt'l* appellate court noted that AMI and AMI-Chanco were parties in the Court of Claims litigation, but refused to apply the doctrine of collateral estoppel on the ground that it "patently would be unfair" to apply one rule for AMI and AMI-Chanco, and another for the other subsidiaries. *AMInt'l*, 677 F.2d at 124.

There are special circumstances that warrant an exception to the collateral estoppel doctrine in the context of the development of the litigation concerning Medicare's reimbursement of stock maintenance costs. In the first place, the law as it has developed does not require application of the doctrine against these plaintiffs in this case. Collateral estoppel is an equitable doctrine; it should not be applied when it would be unjust. *Montana*, 440 U.S. at 155 & 164 n. 11; *Parklane Hoisery*, 439 U.S. at 331 & n. 15; *Red Lake Band v. United States*, 667 F.2d 73 (Ct.Cl. 1981); *Nations v. Sun Oil Co. (Del.)*, 705 F.2d 742, 744 (5th Cir. 1983); *United States v. I.T.T. Rayonier*, 627 F.2d 996, 1000 (9th Cir. 1980); *In re Cenco Inc.*, 529 F. Supp. 411 (N.D. Ill. 1982); *Defenders of Wildlife v. Andrus*, 77 F.R.D. 448 (D. D.C. 1978); Restatement of Judgments § 70 (1942); 1B Moore's Federal Practice, § 0.442 [2], at 751 (2d ed. 1983).

It would be inequitable and unjust to deny reimbursement for 1972-73 cost years to those plaintiffs who had previously been allowed such reimbursement in the Court of Claims for 1969-71 costs. Similarly, it would be unjust to deny other plaintiffs, who are related financial interests, reimbursement for 1969-71 costs that have been determined by the Court of Claims in *AMI-Chanco* to be reimbursable.

The policy reason for the collateral estoppel doctrine is to conserve judicial resources, discourage multiple lawsuits which seek the most favorable court results, and prevent inconsistent decisions. *Montana*, 440 U.S. at 153-54. In this case, however, the change in the forum for Medicare appeals was mandated by statute, and plaintiffs had no choice but to go to the district court to appeal disallowance of post-June 30, 1973, costs. There would have been no relitigation had the Administrator followed the Court of Claims decision in *AMI-Chanco*, or had not delayed administrative action to resolve costs for periods pre-June 30, 1973, for 15 months

pending the appeal in *AMInt'l*.

For the foregoing reasons, and in order to secure the benefits to be derived from a preservation of the conflict between the circuits in this particular factual nexus, the doctrine of collateral estoppel should not be applied. As to the substantive merits of reimbursements for stock maintenance costs for the years in issue, this court is bound by the Court of Claims decision in *AMI-Chanco*. Accordingly, plaintiffs' motion for summary judgment is allowed and defendant's cross-motion is denied.

Plaintiffs' complaint states the stock maintenance costs in issue amount to $1,097,818. Defendant's motion for summary judgment is a recognition that no material facts are in dispute. The administrative record, however, indicates such costs in fact may be a lesser amount. In order that final judgment may be entered expeditiously, counsel are directed to file a stipulation, on or before April 20, 1984, as to the exact amount plaintiffs are entitled to recover.

/s/ Kenneth R. Harkins
KENNETH R. HARKINS, JUDGE
United States Claims Court

APPENDIX J.

Memorandum of Decision.

Superior Court of the State of California for the County of Los Angeles.

American Medical International, Inc., etc., et al., Petitioners, vs. Beverlee A. Myers, etc., Respondent. No. C 348219.

Pursuant to stipulation of the parties, the matter is before the Court in the following posture: Each side seeks summary adjudication on the issues of whether petitioner is entitled to reimbursement for its "stock maintenance costs," as that phrase has been defined in the moving and opposing papers. THE Parties agree on the definition, there is no dispute as to whether the amount allocated to this item by petitioner is reasonable; the parties agree that it is, but dispute whether petitioner is entitled to reimbursement under the applicable statutes and regulations. Petitioner seeks summary adjudication that it is and respondent seeks a determination that it is not.

The Court has determined that these costs are not reimbursable. Respondent is to prepare an Order of Summary Adjudication of Issue accordingly.

The Court has reviewed the extensive arguments presented on both sides, and the applicable authority. *AMI-Chanco, Inc. v. United States* (Ct.Cl.1978) 876 F. 2d 320 favors petitioners, and *American Medical International v. Secretary of H.E.W.* (D.D.C., 1979) 466 F. Supp. 605, and as affirmed (D.C. Cir., 1981) 677 F. 2d 118 favor respondent. And each side has certain inconsistencies in its position that it has not satisfactorily explained.

It is clear that the federal statute contemplates reimbursement to Medicare Health providers for the cost of delivering health care to patients, and authorizes the Department of

Health and Human Services to determine these costs in accordance with regulations it is to promulgate; and that those regulations limit reimbursable costs to those "related to the care of beneficiaries." As petitioner concedes, this is a limited system of reimbursement; it does not recognize all expenses incurred in the course of the business of providing care to Medicare beneficiaries. Thus, advertising costs are not allowed, even though these are, obviously, a deductible expense to the provider. The federal agency charged with administration of the Medicare statute has consistently construed the law and its implementing rules, as not allowing reimbursement to a health care provider of stock maintenance costs. This interpretation, which is also followed and applied by the State respondent, is entitled to deference, although not to blind adherence. See *Pearson v. State Social Welfare Board* (1960) 54 C. 2d 184,210, and more recent authorities cited in respondent's papers. The Court is satisfied that the agency conclusion that the expense of stock transfers to shareholders meetings and other stock maintenance costs are so attenuated from patient care as not to be reimbursable, is reasonable.

Date: February 16, 1984.

[Stamp] NORMAN L. EPSTEIN
NORMAN L. EPSTEIN
Judge of the Superior Court